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CUMBERLAND COUNTY COUNCIL

THE HEALTH OF
CUMBERLAND
1966

REPORT OF THE
COUNTY MEDICAL OFFICER

COUNTY COUNCIL OF CUMBERLAND

ANNUAL REPORT

ON THE

HEALTH OF THE COUNTY

FOR THE YEAR 1966

JOHN LEIPER, M.B.E., T.D., M.B., Ch.B.,
M.R.C.S., L.R.C.P., D.P.H.,
County Medical Officer.

INDEX

	Page
Committee	3
Preface	7
Staff	13
Administration	25
Statistical and Social Conditions of the Area	31
Nursing Services	41
Care of Mothers and Young Children	93
Vaccination and Immunisation	131
Prevention of Illness, Care and Aftercare	139
Welfare Services	165
Mental Health	213
Ambulance and Sitting Case Car Service	237
General Public Health	257
Appendices, I, II, III and IV, Chest Diseases, Mass Radiography and County Council Clinics	273

	Page		Page
Cervical Cytology	143	Inspection and Supervision	
Child Welfare Centres	112	of Food	262
Chiropody	154	Marriage Guidance Councils	123
Congenital Malformations... ..	99	Measles Vaccination	138
Convalescence	151	Midwifery Service	54
Dental Service	108	Nurseries and Child Minders	122
Diphtheria Immunisation	135	Perinatal Mortality	96
Domiciliary Physiotherapy		Prematurity	101
Care	148	Poliomyelitis Vaccination	138
Family Planning	120	Return to Nursing	73
Fluoridation	110	Smallpox Vaccination	137
Health Education	125	Tetanus Immunisation	136
Health Visiting	63	Tuberculosis	145
Home Help Service	83	Unmarried Mothers	103
Home Nursing	70	Venereal Diseases	159
Housing	272	Water and Sewerage	269
Infant Mortality	98	Welfare Foods	106
Infectious Diseases	259	Whooping Cough	
		Immunisation	135

HEALTH, HOUSING AND WELFARE COMMITTEE, 1966

Chairman: Alderman Mrs. E. G. Cain, O.B.E., J.P.

Vice-Chairman: Lady Inglewood, J.P.

Aldermen:

Curwen, Mrs. J. N. St. G., J.P.	MacInnes, Miss J. E.
McCann, Rev. F. K.	Stephenson, W., J.P.
	(died 20/11/66)

Councillors:

Bainbridge, J. J.	McKeating, Mrs. B. O.
Blair, J.	McPoland, Mrs. F., J.P.
Cross, P. G.	Nixon, W. G., J.P.
Dickinson, D.L.	Ruddy, J. M.
Gaffney, C.	Smith, Mrs. M., J.P.
Johnston, T. W.	Thomas, H.
Kilbride, J.	Wilson, Mrs. M. A., J.P.
Lovell, J.	

Ex-officio Members:

Chairman of County Council: Westoll, J., D.L., J.P.

Vice-Chairman of County Council: Dickinson, R. F., D.L., J.P.

Chairman of Finance Committee: Highton, L., D.L., J.P.

Chairman of Education Committee: Jackson, W.

External Members:

Carr, R.	Ingall, Dr. G. M.
Collins, R. G.	Kessell, Mrs. D. R.
Douglas, Mrs. M. B.	Perrott, Dr. E. A.
Duff, Mrs. H.	Roebuck, C. M.
Ferguson, Dr. T. T., J.P.	Stout, Mrs. K. N. L.
Grant, Dr. R. N. R.	Young, A., M.B.E.

NORTHERN AREA (HEALTH) SUB-COMMITTEE

Chairman: MacInnes, Miss J. E.

Vice-Chairman: Wilson, Mrs. M. A., J.P.

Councillors:

Blair, J.

Johnston, T. W.

Dickinson, D. L.

Smith, Mrs. M., J.P.

Ex-officio Members:

Chairman of County Council: Westoll, J., D.L., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E., J.P.

Vice-Chairman of Health Committee: Lady Inglewood, J.P.

Chairman of Education Committee: Jackson, W.

External Members:

Barton, Dr. E. B.

Hodgson, J. J.

Carr, R.

(appointed 16.9.66).

Cross, W. D.

Ingall, Dr. G. M.

Douglas, Mrs. M. B.

Raven, M.

Duff, Mrs. H.

Slee, E. J.

Glaister, N. A.

Todd, Dr. K.

Herbert, H. H.

Windle, Miss S.

Wright, T.

HOUSE SUB-COMMITTEE

Barton, Dr. E. B.

MacInnes, Miss J. E.

Duff, Mrs. H.

Smith, Mrs. M., J.P.

Johnston, T. W.

Wilson, Mrs. M. A., J.P.

Ex-officio Members:

Chairman of County Council: Westoll, J., D.L., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E., J.P.

Vice Chairman of Health Committee: Lady Inglewood, J.P.

SOUTHERN AREA (HEALTH) SUB-COMMITTEE

Chairman: McPoland, Mrs. F., J.P.

Aldermen:

McCann, Rev. F. K.

Stephenson, W., J.P.

(died 20.11.66)

Councillors:

Cross, P. G.

Kilbride, J.

Gaffney, C.

Ruddy, J. M.

Ex-officio Members:

Chairman of County Council: Westoll, J., D.L., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E., J.P.

Vice-Chairman of Health Committee: Lady Inglewood, J.P.

Chairman of Education Committee: Jackson, W.

External Members:

Billing, I. S.

Reed, Mrs. F. M.

Dunne, D.

Roebuck, C. M.

Grice, R. G.

Simpson, K. H.

Kessell, Mrs. D. R.

Stout, Mrs. K. N. L.

Martin, R. B.

Walsh, J., M.B.E., J.P.

(appointed 7.6.66)

Wandless, Miss M. I.

Perrott, Dr. E. A.

Wilson, K.

House Sub-Committee

Cross, P. G.

Martin, R. B.

Hannah, W.

(appointed 20.9.66)

Kilbride, J.

McPoland, Mrs. F., J.P.

Walsh, J.

Ex-officio Members:

Chairman of County Council: Westoll, J., D.L., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E., J.P.

Vice-Chairman of Health Committee: Lady Inglewood, J.P.

WESTERN AREA (HEALTH) SUB-COMMITTEE

Chairman: McKeating, Mrs. B. O.

Vice Chairman: Nixon, W. G., J.P.

Alderman: Curwen, Mrs. J. N. St. G., J.P.

Councillors:

Bainbridge, J. J.

Thomas, H.

Lovell, J.

Ex-officio Members:

Chairman of County Council: Westoll, J., D.L., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E., J.P.

Vice-Chairman of Health Committee: Lady Inglewood, J.P.

Chairman of Education Committee: Jackson, W.

External Members:

Collins, R. G.

Potts, C. R.

Fawcett, J. W.

Smith, Miss D. S.

Ferguson, Dr. T. T.

Smith, Mrs. M.

Graham, Miss E.

Smith, Mrs. M. A.

Grant, Dr. R. N. R.

Thomas, Mrs. A. B., J.P.

Hogarth, S. T.

Young, A.

Holding, W. D.

HOUSE SUB-COMMITTEE

Bainbridge, J. J.

Nixon, W. G., J.P.

Fawcett, J. W.

Young, A.

McKeating, Mrs. B. O.

Ex-officio Members

Chairman of the County Council: Westoll, J., D.L., J.P.

Chairman of Health Committee: Cain, Mrs. E. G., O.B.E., J.P.

Vice-Chairman of Health Committee: Lady Inglewood, J.P.

PREFACE

To the Chairman and Members of the County Council,

I have the honour to present my Annual Report on the health of the County of Cumberland for the year 1966.

This year has been one in which we have seen the shake out of the health services totally caring for the patient outside hospital and the start of the settling down to a new pattern. The pattern shown in the following pages is, I believe, a sound one as there has been proper socio-medical planning for this development by the local health authority.

The Medical Officer of Health who is medical advisor of his local health authority must surely also be the medical organiser of total patient care outside hospital. This concept has now been accepted generally in this County along with the general concept that team work between and within the three branches of the service is taking over from the isolation of individual effort.

In a rural county such as Cumberland, with next to the lowest density of population per acre of any English county, the sparseness of the population means that family doctors, and district nurses, are spending large parts of their day on visits to patients in their own homes. I have wondered whether the time has not arrived to consider the possibility that some of this time may not be spent to the best advantage of the patient, nor, indeed of the professional man or woman. Is there a case for some of the patients from outlying areas being brought in by transport, either their own—and one must not forget there are 36,000 car registrations today in the County—or even by some form of ambulance transport, to surgeries and medical or health centres? The professional man-power position is such that this step would seem to be logical and doctors and nurses in such a very rural area would spend more of their time doing the work that only they can do.

Turning now to the nursing services—first midwifery—the general domiciliary midwifery situation has changed in the manner which has been forecast in recent Annual Reports and a 3%

drop in the percentage of home confinements to 15% has taken place in the year. With 500 confinements in the home in a county with an area of close on a million acres one can readily see that a midwife must have an extended area. Then, in order to be available when the need arises she should be capable of being alerted by radio when out on her rounds. A trial scheme for mobile transmitter/receiver sets in nine midwives' cars is now in process of being put into operation.

In West Cumberland, Part II midwifery training has proved to be a source of growing difficulty. There are insufficient domiciliary midwifery cases now to meet the statutory requirements of this training. The continuance of full training school status for the West Cumberland Hospital is strongly desired by the Hospital authority in the interests of recruitment and staffing. Yet the whole tide of events is towards a situation in this county where, within five to ten years, almost every confinement will take place in hospital. To attempt to perpetuate Part II training for domiciliary midwifery in this situation seems illogical.

At the time of writing this report it is hoped that a revised training scheme reflecting more the modern concept of the domiciliary midwife as one who is working closely with the general practitioner obstetrician, especially in ante and postnatal work and who is expert in the developmental progress of the neonate could be drawn up and approval to it sought from the statutory body concerned, the Central Midwives Board.

Secondly, the home nursing situation has now settled down and nurses are professionally feeling more contented in their new role of work in complete association with a general practitioner or a group of general practitioners. There are still some instances however, in some very rural and isolated parts of the county where the nurses should continue to be geographically based rather than members of a team.

The number of home nursing visits paid last year has been the highest ever and this indicates in one way the success of the nurse attachment to practices. Some eight home nurses are also giving surgery treatment to patients of family doctor groups.

who are attending the surgery and this seems to be a very satisfactory way of meeting the needs of the patients.

Turning to the last section of public health nursing—health visiting—it continues to be more selective. The interesting point to me in the year has been the realisation that in the community there are many health visitors who have married, had children, and who are willing to come back to part-time work. There were three such nurses employed last year and this concept of part-time health visiting in association with full-time health visitors attached to general practitioner groups is one which is becoming clearer.

The nursing services work has been crowned during the year by the return of the lowest ever perinatal rate for this county and a vast increase in the effective work that has been done for the other risk groups, i.e., physically handicapped, cases of mental disorder and elderly cases in the community. It is also with these groups that the voluntary organisations give such wonderful help and support, making this county a participant society.

A 'Return to Nursing' Club has been started following advertisements in the local press, and somewhere in the region of 180 qualified nurses replied saying they were interested in joining such a Club. A short course over six weeks has been arranged for certain volunteers in order to make them aware of the developments in community care since they left nursing. An increasing number of nurses are being appointed on a part-time basis to help in the attachment schemes that are developing in the county. A fuller account of this project is included in the section of the report dealing with Nursing Services.

For some years now courses have been arranged at various centres in Cumberland principally for the inservice training of our own staff, although they have been open also to the staff of other authorities. Many authorities from the North of England and South of Scotland have sent staff and this would seem to me to indicate that there is a significant unmet need for regional training centres to be set up for all types of staff employed by local health and welfare authorities.

The changes that occurred elsewhere in general practice have been reflected in the increased discussion that has taken place about health centres. It now appears that the policy of the Council in staff attachment is proving a very appropriate precursor of thought in regard to the use of health centres; having staff securely attached will, I am sure, greatly facilitate the smooth operation of health centres.

The situation in Cumberland in respect of social work generally is a happy one although at the present time the picture is somewhat confused.

During the year four of the sixteen social welfare officers have been seconded for one or two year courses leaving the day to day commitments in the hands of four younger men and women who have already come back from training, three who are already trained by experience, and five untrained workers.

In the social field the most important change has been the work done at the post-psychotic Hostel in the rehabilitation of cases of mental disorder, mostly long-term post-psychotic cases re-entering the community. I cannot speak too highly of the excellent work that has been done there by the Consultant Psychiatrist (Dr. A. W. Drummond), the Matron (Mrs. M. Cowham) and her staff, and the social workers, with little help from other organisations. I feel completely convinced myself, however, of the immense value of this Hostel in the community care of cases of mental disorder.

A fundamental point in respect of community care for the elderly in this county is the realisation that during the year there was a net outward migration from Cumberland—and in this general respect this county is no different from our neighbours—of 3.7 persons per day but at the same time there was an increase in the elderly population of a little more than one aged person per day.

Community care has developed well in the year in that the links of the social welfare officers with hospital workers has improved generally. There is an interchange and an intermingling

of professional information and an easy reference from and to the hospital of information and action to the patient's or client's benefit.

I am now less unhappy about the possibility that the ambulance service in this wide ranging county should be transferred to the control of the Regional Hospital Board—the major user. For some five years now the Cumberland Health Committee have been interested in a joint ambulance committee to run a combined service for the Special Area. Obvious reaction from this type of thought is that regional control will be more effective and efficient in a situation where the major user is the hospital.

An attempt to improve the clerical procedure for schemes of immunisation by data processing through the computer in the County Treasurer's department has, unfortunately, had to be shelved on financial grounds. This is a great pity but it is hoped the authority will be able to meet the relatively small extra cost in order to modernise this procedure for the efficient prevention of the common infectious diseases of yesterday.

I have been impressed during the year by increasing difficulty in attracting into mixed appointments suitably qualified doctors to undertake district council public health work, together with duties in the county health and welfare service. There would seem to me to be some urgent need for some form of reorganisation in the medical staff structure of health and welfare departments, and I think I have already written enough to indicate that this is just part of a general pattern of re-examination of the needs of particular groups of staff.

At the same time I feel that this is every reason why we should go ahead to examine staff needs in respect of the next two decades so that the staff establishment may be evolved which is in keeping with the needs to come rather than the needs of the past situation. On no account must we plan for the needs of tomorrow with the establishment of yesterday.

Changes in personnel constantly occur but the year has seen the death of the Southern Area Medical Officer, Dr. J. N. Dobson, whose pioneer work in public health in that area and whose deep

and constant care for the handicapped child will long be remembered. Mrs. A. Steele, an area nursing officer since 1948, has also retired, and her services will be greatly missed for some time. Her deep appreciation of individual needs of patients and families, and the quick and proper meeting of those needs by her trained staff, coupled with a great compassion for her work, were attributes which we all clearly saw in her.

My thanks go out to the Chairman of the Health Committee for her constant support and steady guidance, and the staff of the Health Department for their consistently fine work often under arduous circumstances in a year of such progress.

I am, Ladies and Gentlemen,

Your Obedient Servant,

John Leiper.

County Health Department,
11, Portland Square,
Carlisle.
Tel. No. Carlisle 23456.

MEDICAL, DENTAL AND ANCILLARY STAFF

County Medical Officer and County Welfare Officer—

J. Leiper, M.B.E., T.D., M.B., Ch.B., M.R.C.S., L.R.C.P.,
D.P.H.

Deputy County Medical Officer and Deputy County Welfare Officer—

J. D. Terrell, M.B., Ch.B., D.P.H., D.C.H.

Area Medical Officers and District Medical Officers of Health—

J. N. Dobson, M.B., Ch.B., D.P.H., (Died 13.10.66). Southern Area Medical Officer, Medical Officer of Health Whitehaven Borough and Ennerdale Rural District.

J. L. Hunter, M.B., Ch.B., D.P.H., Western Area Medical Officer and Medical Officer of Health Workington Borough.

F. S. Rogers, M.B., Ch.B., D.P.H., (Commenced 5.1.66), Northern Area Medical Officer and Medical Officer of Health to Border Rural District Council.

W. S. Slater, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.H. (Commenced 1.3.66), Deputy Southern Area Medical Officer, Medical Officer of Health Millom Rural District

J. Patterson, M.B., B.Ch., B.A.O., D.P.H., Deputy Western Area Medical Officer, Medical Officer of Health Cockermouth Rural and Urban District and Keswick Urban District (Resigned 31.5.66).

A. Hargreaves, M.B., Ch.B., D.P.H. (Commenced 1.9.66). Deputy Western Area Medical Officer, Medical Officer of Health Cockermouth Rural and Urban Districts Keswick Urban District.

K. J. Thomson, M.B., Ch.B., D.P.H., L.M., Deputy Northern Area Medical Officer, Medical Officer of Health Border Rural District and Penrith Rural District. (Resigned 16.1.66).

Assistant County Medical Officers and District Medical Officers of Health—

E. M. O. Campbell, M.B., Ch.B., D.P.H., D.T.M. and H.,
Medical Officer of Health Maryport Urban District.

D. H. Chowdhury, M.B., B.S., D.P.H., Medical Officer of
Health Penrith Rural District and Penrith Urban District.

J. R. Hassan, M.B., Ch.B., D.Obst. R.C.O.G., Medical Officer
of Health Alston Rural District (also General Practitioner).

Assistant County Medical Officers—

J. E. Ainsworth, M.B., Ch.B.

H. M. Marks, M.B., Ch.B.

M. Timperley, M.B., Ch.B.

K. R. Walker, M.B., Ch.B.

DENTAL

Chief Dental Officer—

R. B. Neal, M.B.E., T.D., L.D.S.R.C.S.

Area Dental Officer—

I. R. C. Crabb, L.D.S.R.F.P.S.

Dental Officers—

J. A. G. Baxter, L.D.S.R.C.S.

J. Docherty, B.D.S. (Commenced 1.10.66)

A. B. Gibson, B.D.S.

M. Green, L.D.S.R.C.S.

F. H. Jacobs, L.D.S.

I. H. Parsons, L.D.S.

A. R. Peck, L.D.S.

A. M. Scott, L.D.S.

WELFARE SERVICES

Welfare Services Officer—

S. Hodgson, M.B.E., F.C.C.S.

Deputy Welfare Services Officer—

N. Froggatt.

Social Welfare Officers—

Northern Area

Miss E. A. Welch, A.A.P.S.W., Senior Welfare Officer.

A. Hill

G. A. H. Miller

I. H. Moffet, C.S.W.

M. H. Payne

W. H. Robinson (part-time).

Western Area

Miss E. F. Hall, Senior Welfare Officer.

G. Cowham, R.M.N., C.S.W.

A. Davidson, R.M.N., S.R.N.

A. Irving.

Southern Area

A. F. Barlee, B.Sc., Econ., Senior Welfare Officer.

J. Allison.

R. Daley.

J. Gibson (part-time)

J. C. Tanti (resigned 6.11.66).

J. M. Ruddick, C.S.W. (Commenced 11.7.66).

Trainee Welfare Officer—

Miss L. O'Hare

Manager/Matron of Residential Accommodation—

Mrs. M. Beresford, Grisedale Croft, Alston.

Mrs. M. Campbell, Castle Mount, Egremont.

Mrs. M. Cowham, Post Psychotic Hostel, Fairview, Bransty,
Whitehaven.

Mrs. H. Day, S.E.N., Richmond Park, Workington.

Miss E. T. Durkan, The Croft, Kirksanton.

Miss B. Edgar, Grange Bank, Wigton.

Mrs. M. M. Ferguson, Highfield House, Wigton(Commenced
1.5.66.)

Mrs. A. Hill, Station View House, Penrith.

P. A. Howe, Highfield House, Wigton (Retired 28.2.66.)

Mrs. M. Melville, Moot Lodge, Brampton (Commenced
1.4.66.)

Mrs. H. S. Milnes, Derwent Lodge, Papcastle.

Miss A. G. Ross, S.R.N., Parkside, Maryport.

Mrs. D. Smitham, S.R.N., Garlieston, Whitehaven.

Mrs. R. Wilson, S.R.N., Brackenthwaite, Whitehaven
(Commenced 1.7.66.)

Miss V. Woodman, S.R.N., The Towers, Skinburness.

Home Teachers for the Blind—

Miss J. Burgess

Miss L. D. Fraser

Mrs. G. Hawthorn (part-time—resigned 24.6.66.)

Mrs. G. Mossop.

Miss M. Shuttleworth.

Training Centre Supervisors—

J. J. Lace, Distington

Miss A. Love, Whitehaven

Miss G. L. Lister, Wigton.

Consultant Psychiatrists (part-time) seconded from Newcastle upon Tyne Regional Hospital Board—

T. R. Burgess, M.R.C.S., L.R.C.P., D.P.M. (Commenced 5.9.66.)

J. R. Stuart, M.B., Ch.B., D.P.M.

T. T. Ferguson, L.R.C.P., L.R.C.S., L.R.F.P.S.

NURSING STAFF

Superintendent Nursing Officer—

Miss I. Mansbridge, M.B.E., S.R.N., S.C.M., Q.N., H.V.Cert.

Deputy Superintendent Nursing Officer—

Miss M. Blockey, S.R.N., R.S.C.N., S.C.M., Q.N., H.V.Cert.

Nurses' Qualifications Code:

1. State Registered Nurse (or Registered General Nurse).
2. State Certified Midwife.
3. Queen's Nurse.
4. Health Visitor's Certificate
5. Registered Fever Nurse
6. State Enrolled Nurse.
7. Registered Sick Children's Nurse.
8. Orthopaedic Nursing Certificate.
9. Diploma in Tropical Nursing.

NORTHERN AREA

Northern Area Nursing Officer—

Miss J. M. Till, S.R.N., S.C.M., H.V.Cert., Q.N., D.T.N.
(Commenced 1.9.66.)

Health Visitors—

Miss M. M. Butler, 1, 2, 3, 4.	Longtown
Miss E. M. Chalkley, 1, 2, 3, 4.	Penrith
Miss A. Dixon, 1, 2, 3, 4.	Penrith
Mrs. E. J. Edwards, 1, 2, 4. (part-time)	Hesket
Miss E. Henderson, 1, 2, 3, 4.	Penrith
Miss B. W. Knibbs, 1, 2, 3, 4.	Brampton
Miss E. A. Lockhart, 1, 2, 3, 4.	Brampton
Mrs. A. W. E. Maughan, 1, 2, 4.	Penrith
Miss E. Mercer, 1, 2, 4, 5.	Wigton
Mrs. M. McCredie, 1, 2, 4. (part-time)	Lazonby
Mrs. M. C. Roberts, 1, 2, 4.	Aspatria

All the above are seconded to General Practitioners.

Health Visitor/Midwife—

*Mrs. M. Dobson, 1, 2, 3, 4.	Houghton
------------------------------	----------

Home Nurse/Midwives—

*Miss J. R. N. Byres, 1, 2, 3, 5.	Hesket/Lazonby
*Miss A. A. Cockton, 1, 2.	Burgh-by-Sands/ Kirkbride
Miss V. Dodgson, 1, 2.	Abbeytown
Miss L. R. Douglass, 2, 6.	Skelton/Greystoke
*Miss M. Hope, 1, 2, 3.	Wigton
*Mrs. F. M. Hurst, 1, 2, 3.	Bewcastle/Brampton
*Miss G. Jobson, 1, 2, 3.	Silloth
*Mrs. D. M. Lancaster, 1, 2, 3, 4.	Wigton
*Mrs. I. Penn, 1, 2, 3.	Penrith
*Mrs. A. Richardson, 1, 2, 3.	Aspatria
*Mrs. M. E. Wilde, 1, 2, 3.	Dalston/Thursby
*Miss K. Winter, 1, 2, 3.	Penrith
*Mrs. E. M. Walton, 1, 2, 9. (part-time)	Alston

Home Nurse/Midwife/Health Visitors—

- | | |
|----------------------------------|--------------|
| *Miss A. Bowler, 1, 2, 3, 4. | Caldbeck |
| *Mrs. M. J. Mathews, 1, 2, 3, 4. | Watermillock |

Home Nurses—

- | | |
|-----------------------------------|---------------------------------|
| *Mrs. J. A. Branthwaite, 1, 3. | Houghton/Hayton |
| *Mrs. F. A. Gaskin, 1, 2, 3. | Irthington and part
Brampton |
| Mrs. H. Harper, 1.
(part-time) | Longtown |
| Mrs. M. Hope, 1, 2, 3. | Relief. (Wigton) |
| Mrs. V. M. Lamb, 1, 2. | Langwathby/Skirwith |
| *Mrs. G. Nixon, 1, 2. | Penrith |
| *Mrs. D. J. Patterson, 1. | Relief. (Brampton) |
| *Mrs. E. J. Relph, 1, 3. | Penrith |
| Mrs. D. M. Scoon, 6. | Relief (Watermillock) |
| Mrs. M. Vevers, 1.
(part-time) | Longtown |
| *Miss M. Weightman, 1, 2, 3. | Scotby/Wetheral |
| *Miss B. M. Wesson, 1, 2, 3. | Farlam and part
Brampton. |

Clinic Nurse—

- | | |
|--|-----------|
| Mrs. E. M. Stafford, 1. | Part-time |
| *Nurses seconded to General Practitioners. | |

WESTERN AREA

Area Nursing Officer—

Mrs. A. Steele, S.R.N., S.C.M., Q.N., H.V., Cert.

Health Visitors—

*Miss M. Casey, 1, 2, 3, 4.	Keswick
*Miss G. Davies, 1, 3, 4.	Workington
*Mrs. A. Donald, 1, 2, 3, 4, 7.	Maryport
*Mrs. B. L. Goodson, 1, 2, 4.	Workington (Retired 30.12.66.)
*Miss A. M. Greggain, 1, 2, 3, 4.	Bassenthwaite
*Mrs. M. Hewitson, 1, 2, 4.	Workington
*Miss M. Horn, 1, 2, 4, 5.	Cockermouth (Retired 12.1.66.)
*Miss A. Jackson, 1, 2, 4.	Workington
*Miss F. Kendall, 1, 2, 4.	Maryport (Retired 12.1.66.)
*Miss A. K. Loo, 1, 4.	Workington (Resigned 31.12.66.)
*Mrs. M. Lythgoe, 1, 2, 4.	Cockermouth
*Miss J. E. Surtees, 1, 2, 4.	Workington
*Miss S. Twigg, 1, 2, 3, 4.	Maryport

Home Nurse/Health Visitor—

*Miss M. P. Reynolds, 1, 2, 4. 50% D.N. 50% H.V.	Lorton
---	--------

Home Nurse/Midwives—

*Miss A. Chadwick, 1, 2, 3.	Maryport
*Miss S. J. Graham, 2, 6.	Brigham
*Miss S. M. J. Iliffe, 1, 2, 3.	Borrowdale
*Miss A. I. Kirk, 1, 2, 3.	Cockermouth
Mrs. H. M. McCallam, 2, 6.	(Full-time relief)
*Miss M. Musgrave, 1, 2, 3.	Cockermouth
*Miss O. Pickering, 1, 2, 3.	Maryport.

Midwives—

Mrs. M. M. Hind, 2, 6.	Workington (Retired 6.11.66.)
Mrs. A. Maguire, 2.	Workington.
Mrs. M. K. Tunstall, 1, 2.	Workington.

Home Nurses—

*Mrs. B. P. Ashe, 1.	Braithwaite
Mrs. J. E. Barnes, 1, 2, 3.	(Part-time relief)
*Mrs. J. M. Clark, 1, 2.	Relief (part-time)
*Mrs. A. M. Edgar, 1, 2.	Threlkeld
*Mrs. E. Fagan, 1, 3, 5.	Relief (Part-time)
*Mrs. M. Hamilton, 1, 3.	Workington
Mr. T. D. Holmes, 1, 3.	Workington
*Mrs. M. I. Lowis, 1, 3.	Workington
*Mrs. K. Lytollis, 1.	Relief (part-time)
*Mrs. L. Messenger, 1, 2, 3.	Workington
*Mrs. J. Palin, 1, 3.	Workington
Mrs. S. E. Scott, 2, 6.	Relief (Part-time)
*Mrs. V. Sherwood, 1, 3, 8.	Broughton
*Mrs. R. Stephenson, 1, 2, 3.	Workington
*Mrs. M. M. Swinburne, 1, 2.	(Part-time relief)
*Mrs. C. M. Tebay, 1.	Relief (Part-time)
*Mrs. M. Young, 1, 2, 3, 7.	Workington
Mrs. M. B. White	Relief (Part-time)
*Mrs. E. Beckwith, 1 and District Training	Dearham
*Mrs. C. M. Gate, 1, 2, 3.	Maryport.

School/Clinic Nurses—

Mrs. M. E. Sanson, 1, 2, 5.	Maryport.
Miss D. Wise, 1, 2, 3, 5, 9.	Workington

*Nurses seconded to General Practitioners.

SOUTHERN AREA

Area Nursing Officer—

Miss J. Reid, S.R.N., S.C.M., Q.N., H.V.Cert.

Health Visitors—

Mrs. E. A. Aderinola, 1, 2, 4.	Millom (Resigned 28.2.66)
Miss I. M. Alcock, 1, 2, 4.	Whitehaven
Mrs. I. E. Bowe, 1, 2, 3, 4.	Millom
Mrs. S. Crellin, 1, 2, 4.	Whitehaven
Miss E. Crosby, 1, 2, 4.	Ennerdale
Miss M. E. Gibson, 1, 2, 4.	Ennerdale
Miss A. M. Little, 1, 2, 4.	Millom (Retired 3.8.66.)
Miss R. A. Lodge, 1, 2, 4.	Whitehaven.
Mrs. A. W. Lynn, 1, 2, 3, 4.	Millom (Part-time)
Mrs. A. Petch, 1, 2, 3, 4.	Whitehaven
Mrs. I. J. Smith (nee Hoult), 1, 2, 4.	Ennerdale
Miss R. Sheppard, 1, 2, 3, 4.	Ennerdale
Miss P. Walsh, 1, 2, 4.	Ennerdale

All the above are seconded to General Practitioners.

Home Nurse/Midwives—

*Miss A. Armstrong, 1, 2, 3.	Egremont
*Miss M. G. Beattie, 1, 2, 3.	Millom
*Mrs. I. Booth, 1, 2.	Millom
*Miss C. E. Hall, 1, 2, 3.	Egremont
Miss F. Lonsdale, 1, 2.	Seascale (Retired 2.5.66.)
*Mrs. J. Niles (nee Leadbetter) 1, 2, 3.	Cleator Moor/ Whitehaven (Resigned 6.10.66)
*Miss M. Proctor, 1, 2, 3.	Frizington
*Miss H. Spencer, 1, 2, 3.	Frizington

Midwives—

Mrs. M. Ainsworth, 1, 2.

Miss A. Singleton, 1, 2.

Whitehaven

Whitehaven

(Resigned to take
H.V. training
29.9.66.)

Miss E. M. Miller, 1, 2.

Cleator Moor

Home Nurse/Midwife/Health Visitors—

Mrs. J. A. Graham, 1, 2, 3, 4.

Distington

Miss J. A. G. Hardie, 1, 2, 3, 4.

Parton

*Miss D. D. James, 1, 2, 3, 4.

Seascale/Gosforth

*Mrs. M. Marshall, 1, 2, 3.

Muncaster/Bootle

Home Nurses—

Mr. Anderson, 1, 8.

Whitehaven

*Mrs. E. Brannon, 1, 3.

Whitehaven

*Miss O. G. Coates, 1, 3.

Whitehaven

*Mrs. F. Corkhill, 1, 3.

Egremont

*Mrs. H. Egan, 1, 5.

Whitehaven (Part-time)

*Mrs. E. A. James, 1, 3.

Whitehaven (Part-time)

(Commenced 24.10.66)

Mrs. D. Jolly, 1, 2, 5.

Millom (Relief—
Part-time).

*Mrs. I. Routledge, 1, 2, 3.

Whitehaven

*Mrs. E. Speed-Andrews, 1.

Seascale (Commenced
4.7.66).

*Mrs. M. T. Toole, 1, 3.

Cleator Moor

*Mrs. S. E. Troll, 6.

Millom (part-time)

*Mrs. M. K. Wilson, 1.

Millom/Bootle

*Miss J. Woodend, 1, 3.

Whitehaven

School/Clinic Nurses—

Mrs. M. Hadley, 1, 2, 3.

Millom (Part-time)

(Commenced 12.9.66.)

Mrs. E. M. Maguire, 1, 2, 8.

Whitehaven/Cleator
Moor.

Mrs. B. F. Wilson, 1.

Whitehaven.

*Nurses seconded to General Practitioners.

Audiometricians—

Mrs. M. Cross

Mrs. M. G. Hicks.

Chiropodists—

G. H. Thomas, M.Ch.S.

W. W. Gordon

Mrs. H. Coulson

Mrs. D. E. Smart M.I.C.Ch. (Commenced 5.9.66.)

Orthopaedic Physiotherapists—

Miss J. M. Morris, M.C.S.P., M.E.

Miss J. A. Fraser, M.C.S.P., O.N.C.

Orthoptists—

Mrs. G. Richardson, D.B.O. (part-time).

Mrs. J. Scott, D.B.O. (part-time)

Mrs. L. Tongue D.B.O. (part-time) (Resigned 30.11.66.)

Speech Therapists—

Mrs. E. M. Blacklock, L.C.S.T.

Miss E. B. Moon, L.C.S.T. (part-time).

Mrs. S. Latimer, L.C.S.T. (part-time).

County Ambulance Officer—

M. F. Smith.

Senior Administrative Assistant—

J. J. Pattinson, D.F.C.

ADMINISTRATION

This is the first Annual Report for some time in which I have not been drawing attention to a major administrative or committee re-organisation which was either pending or had been implemented. That is not to say that the year has been without difficulties and devoid of change, but basically it has been a comparatively settled year.

With rather more than two years' experience of area administration I think it can be said that the decentralisation has, in most respects, achieved what was expected of it, although it has been hampered by the long illness and subsequent death of the Southern Area Medical Officer, Dr. Dobson, and a longstanding vacancy for a nursing officer in the Northern Area. I am pleased to say that both vacancies have now been filled.

Briefly, the administrative arrangements are that all day-by-day management of the health and welfare services, with a few exceptions, are delegated to the three Area Medical Officers, who are each responsible to an Area Health Sub-Committee. These sub-committees have a wide representation, including amongst their members representatives of teachers in the area, of each district council, of the Executive Council and the Special Area Committee of the Regional Hospital Board.

The Joint Health and Education Committee deals with matters pertaining to the school health service and health education in general.

A central General Purposes Sub-Committee deals with matters not related to the functions of existing standing sub-committees, matters connected with the ambulance service and such matters of policy as may be referred to it for detailed study.

There is a Joint Sub-Committee consisting of members appointed by the County Council and Carlisle Borough Council to look after the affairs of the Cumberland and Carlisle Workshops for the Blind.

All these sub-committees report to the Health, Housing and Welfare Committee at quarterly intervals, the parent committee being concerned essentially with general policy and finance. Similarly, headquarters administrative staff deal mainly with policy, finance and training, although exercising day to day control over the ambulance service and admissions to Old People's Homes.

With a view to fostering closer liaison between the branches of the health service the authority tried to establish a professional co-ordination group consisting of general practitioners and local authority medical staff. One of its first tasks would have been consideration in detail of the problems surrounding the joint use of staff and premises, although its terms of reference would have been to examine any points of mutual interest to different branches of the service. It was felt that such a group could have performed a most useful function. Even if the general practitioners appointed could not commit their colleagues they would at least have presented some views from general practice and would, therefore, have been a useful "sounding-board" for new ideas. Unfortunately, the Local Medical Committee rejected the idea.

I do, of course, have a valuable liaison with general practitioners through the Local Medical Committee, whose meetings I am able to attend, but I believe that more could be accomplished in many cases by preliminary discussion, probably in more detail, with a smaller group.

The Health and Medical Services Liaison Group meets regularly at six-monthly intervals and is a useful forum for discussing policy and its effects on other branches of the service while the projects are still in their early planning stage or, preferably, at pre-planning stage. The group is not entirely professional and has representatives from this authority, the Carlisle authority, the Special Area Committee of the Regional Hospital Board, Cumberland Executive Council, Carlisle Executive Council and the Cumberland and Carlisle Local Medical Committees.

In addition, the fact that I or my deputy can attend meetings of the West Cumberland Hospital Management Committee, Gar-

lands Medical Advisory Committee and Local Maternity Liaison Committee, while I can attend meetings of the Special Area Committee and the Superintendent Nursing Officer is a member of the East Cumberland Hospital Management Committee, does help to overcome the separation of services which present legislation imposes. The publication of bulletins to keep general practitioners in touch with the work of the department is another attempt at bridging the gap. I believe that these bulletins serve a useful purpose but it is difficult to gauge this accurately as, despite repeated requests, I have very few comments on the contents from doctors.

At the beginning of the year there was some despondency that a capital development programme which promised well for the future had been severely affected by the six months' deferment of capital works brought on by the financial situation in 1965. There was hope that some of the ground could be made up in 1966 but these hopes were dashed when the Ministry approved only four projects out of eight submitted, especially as three of those four had been carried forward from previous years. Particularly hard hit is the provision of Part III accommodation, as this authority was already considerably below the national average number of places and had hoped to attack the problem energetically during the next few years. Now, because of the replacement of ex-Public Assistance Institutions, the authority's programme over the next three years will, in fact, produce few additional places.

The financial situation is also having its effect on the services provided through revenue expenditure and it seems likely that some of the services provided in 1967 will be at a lower standard than before.

The difficulty in filling certain appointments continues, although it is hoped to alleviate the position so far as orthoptists and speech therapists are concerned by the award of scholarships. Suitable pupils at Cumberland Grammar Schools who wish to undergo training are offered scholarships of £450 a year, plus tuition and examination fees and travelling expenses connected with the courses. In return they agree to come back to Cum-

berland to work for at least two years. At present one young lady is undergoing training in orthoptics and another is training in speech therapy. A second trainee for speech therapy has been selected for entry to a training school in 1967.

Twelve months of advertising was necessary to fill one post of Medical Officer, which also carried district M.O.H. duties but I am pleased to say that by the end of the year appointments had been made to all medical posts on the establishment.

AREA ADMINISTRATION

Area	Area Medical Officer	Districts covered	Total acreage	Total population	School population in 1966	Births	Child Welfare Premises	Centres Attendances	Training Centres	Centres Places	Part III Homes	Accomm. Places
Northern	Dr. F. S. Rogers, 13 Portland Square, Carlisle	Alston R.D. Border R.D. Penrith R.D. Penrith U.D. Wigton R.D.	612,000	77,300	12,440	1224	15	9,832	1	45	6	198
Western	Dr. J. L. Hunter, Stoneleigh, Park End Road, Workington.	Cockermouth R.D. Cockermouth U.D. Keswick U.D. Maryport U.D. Workington M.B.	173,000	73,790	12,284	1229	10	8,726	1	50	3	94
Southern	Dr. J. N. Dobson, (Died 12/10/66) Flatt Walks, Whitehaven.	Ennerdale R.D. Millom R.D. Whitehaven M.B.	182,000	74,170	13,887	1217	10	14,963	1	75	4	128



STATISTICAL AND SOCIAL CONDITIONS OF THE AREA

Area in Acres of Administrative County — 967,054 acres.

Rateable Value (April 1st, 1966) — £7,278,966

Estimated Product of 1d. Rate (1966-67) — £28,801.

Population (Census, 1951) — 217,540

Population (Census, 1961) — 223,202

Population (1966 Mid-Year Estimate) — 225,260.

Live Births — Number	...	...	...	...	...	3,670
Rate per 1,000 population	...	...	...	...	...	16.3
Illegitimate Live Births per cent of total births	...	...	...	...	...	5.9
Still Birth — Number	...	...	...	...	...	60
Rate per 1,000 total live and still births	...	...	...	...	...	16.1
Total Live and still births	...	...	...	...	...	3,730
Infant Deaths (Deaths under 1 year)	...	...	...	...	...	77
Infant Mortality Rates—						
Total Infant Deaths per 1,000 total live births	...	...	...	...	...	21.0
Legitimate Infant Deaths per 1,000 total legitimate births	...	...	...	...	...	21.1
Illegitimate Infant Deaths per 1,000 total illegitimate births	...	...	...	...	...	18.6
Neo-natal mortality rate (Deaths under 4 weeks per 1,000 total live births)	...	...	...	...	...	16.1
Early neo-natal mortality rate (Deaths under 1 week per 1,000 total live births).	...	...	...	...	...	10.9
Perinatal mortality rate (Still births and Deaths under 1 week combined per 1,000 total live and still births)	...	...	...	...	...	26.8
Maternal Mortality (including abortion)	...	...	...	...	...	1
Rate per 1,000 total Live and Still births	...	...	...	...	...	0.3

A more detailed analysis of the above figures is given overleaf

		Male	Female	Total	Urban Districts	Rural Districts	Admin. County	Eng'd & Wales (Prov.)
LIVE BIRTHS—								
Legitimate	...	1803	1652	3455				
Illegitimate	...	109	106	215				
		1912	1758	3670				
Birth rate per 1,000 population	...				16.8	16.0	16.3	17.7
STILL BIRTHS—								
Legitimate	...	28	27	55				
Illegitimate	...	4	1	5				
		32	28	60				
Still birth rate per 1,000 total births					18.1	14.7	16.1	15.4
DEATHS—								
All causes	...	1412	1349	2761				
Death rate per 1,000 population	...				12.2	12.3	12.3	11.7
INFANT DEATHS—								
All infants under 1 year of age—								
Legitimate	...	38	35	73				
Illegitimate	...	1	3	4				
		39	38	77				
Total infant deaths per 1,000 total live births	...	...	...	...	21.7	20.5	21.0	19.0

MORTALITY TRENDS IN CUMBERLAND

Year	Under 1	1—	5—	15—	25—	45—	65—	75	Total
1926	...	313 11.4%	164 5.9%	88 3.2%	107 3.9%	274 10.0%	605 22.0%	589 21.4%	2753 Rate 12.7
1936	...	185	62	62	92	229	572	749	2574 Rate 12.9
1956	...	112	12	18	24	112	571	1085	2653 Rate 12.2
1957	...	103	21	19	33	120	553	1057	2640 Rate 12.1
1958	...	108	18	9	24	113	607	1087	2643 Rate 12.1
1959	...	82	8	16	27	81	575	1110	2611 Rate 11.9
1960	...	91	13	19	21	105	554	1149	2629 Rate 12.0
1961	...	88	7	19	19	86	570	1189	2725 Rate 12.3
1962	...	108	15	13	15	114	574	1125	2723 Rate 12.2
1963	...	87	8	11	33	97	648	1208	2813 Rate 12.5
1964	...	76	19	14	24	88	626	1118	2670 Rate 11.8
1965	...	66	11	13	29	89	618	1130	2706 Rate 12.0
1966	...	77	6	13	25	96	588	1224	2761 Rate 12.3
		2.8%	0.2%	0.5%	0.9%	3.5%	21.3%	44.3%	

BIRTHS, DEATHS, INFANT MORTALITY

BIRTHS

District			Legitimate	Illegitimate	Total	Births per 1000 of population (crude)	Comparability factor	Stillbirths	Crude Birth Rate
URBAN DISTRICTS—									
Cockermouth	...	...	103	3	106	17.3	1.00	3	22
Keswick	...	...	61	10	71	16.4	1.12	1	13
Maryport	...	...	204	8	212	17.5	0.96	3	14
Penrith	...	...	156	16	172	15.9	1.00	5	28
Whitehaven	...	...	417	26	443	16.3	0.93	4	9
Workington	...	...	480	37	517	17.2	1.00	12	22
Aggregate	...	...	1,421	100	1521	16.8	0.98	28	18
RURAL DISTRICTS—									
Alston	...	...	24	4	28	13.6	1.25	—	—
Border	...	...	415	25	440	14.2	1.12	5	11
Cockermouth	...	...	307	16	323	15.3	1.02	2	6
Ennerdale	...	...	532	27	559	17.5	0.99	13	22
Millom	...	...	207	8	215	14.3	1.08	2	9
Penrith	...	...	172	13	185	16.1	1.07	3	16
Wigton	...	...	377	22	399	18.2	1.05	7	17
Aggregate	...	...	2,034	115	2149	16.0	1.05	32	14
Administrative County	...	...	3,455	215	3670	16.3	1.02	60	16

AND POPULATION IN THE YEAR, 1966

DEATHS			INFANT MORTALITY ...										
Total Deaths	Deaths per 1,000 of population (crude)	Comparability factor	Total Infant Deaths	Legitimate	Illegitimate	Neonatal Deaths	Early Neonatal Deaths	Infant Death Rate	Neonatal Rate	Early Neonatal Rate	Perinatal Deaths	Perinatal Death Rate	Estimated Mid-year Population
85	13.9	1.08	3	1	2	2	—	28.3	18.9	—	3	27.5	6140
91	21.0	0.82	4	4	—	4	3	56.3	56.3	42.3	4	55.6	4340
169	13.9	1.14	1	1	—	1	—	4.7	4.7	—	3	14.0	12150
143	13.2	0.87	3	3	—	1	1	17.4	5.8	5.8	6	33.9	10840
284	10.5	1.26	10	10	—	5	4	22.6	11.3	9.0	8	17.9	27130
336	11.2	1.12	12	12	—	10	7	23.2	19.3	13.5	19	35.9	29980
1108	12.2	1.11	33	31	2	23	15	21.7	15.1	9.9	43	27.8	90580
23	11.2	0.85	—	—	—	—	—	—	—	—	—	—	2060
430	13.9	0.93	8	8	—	8	5	18.2	18.2	11.4	10	22.5	31060
244	11.5	1.09	4	4	—	3	2	12.4	9.3	6.2	4	12.3	21180
356	11.1	1.23	18	16	2	14	11	32.2	25.0	19.7	24	42.0	31950
156	10.3	1.28	1	1	—	—	—	4.7	—	—	2	9.2	15090
143	12.5	1.03	5	5	—	4	3	27.0	21.6	16.2	6	31.9	11460
301	13.8	0.92	8	8	—	7	4	20.0	17.5	10.0	11	27.0	21880
1653	12.3	1.05	44	42	2	36	25	20.5	16.8	11.6	57	26.1	134680
2761	12.3	1.07	77	73	4	59	40	21.0	16.1	10.9	100	26.8	225260

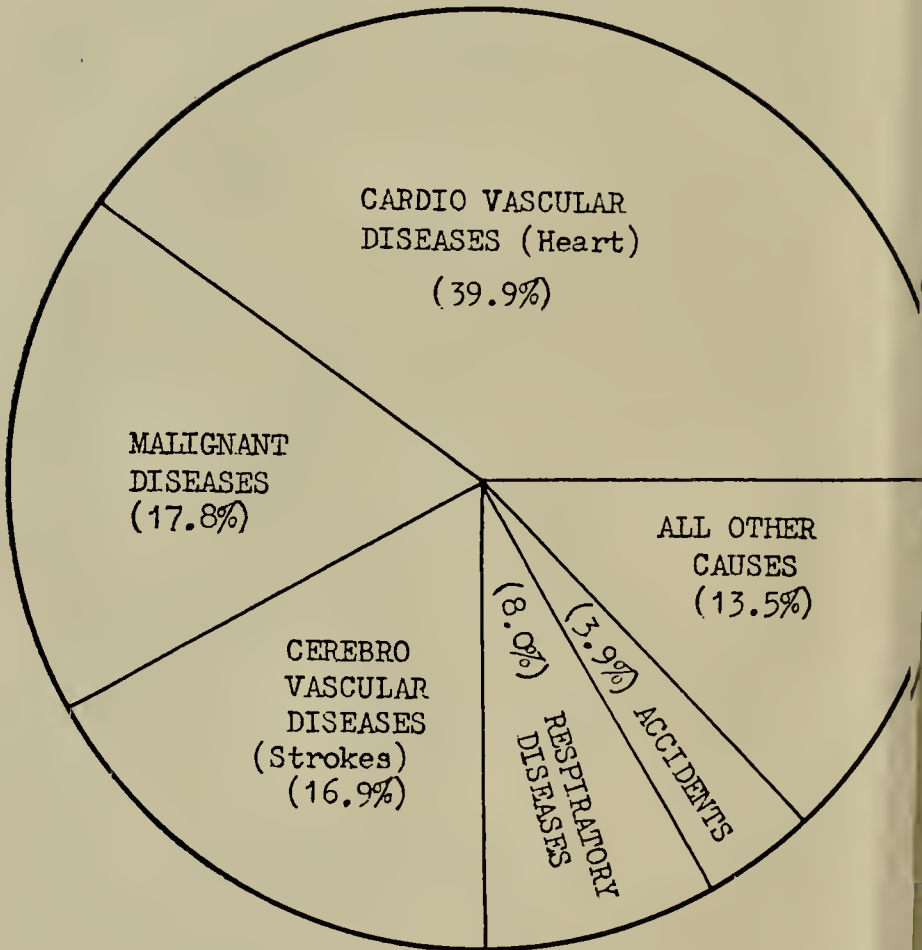
CAUSES OF DEATH IN ADMIN

Cause of Death					Administrative County	Cockermouth U.D.	Keswick U.D.	Maryport U.D.	Penrith U.D.
All Causes					2761	85	91	169	148
1.	Tuberculosis, Respiratory	...	...	...	4	—	—	—	—
2.	Tuberculosis, Other	...	...	...	—	—	—	—	—
3.	Syphilitic Disease	...	...	...	1	—	—	—	—
4.	Measles	...	...	...	1	—	—	—	—
5.	Other infective and Parasitic diseases	...	...	...	1	—	—	—	—
6.	Malignant neoplasm, stomach	...	...	...	67	2	1	4	—
7.	Malignant neoplasm, lung bronchus	...	...	...	85	1	2	9	—
8.	Malignant neoplasm, breast	...	...	...	40	—	3	3	—
9.	Malignant neoplasm, uterus	...	...	...	23	—	—	2	—
10.	Other malignant and lymphatic neoplasms	...	...	...	266	13	12	16	—
11.	Leukaemia, Aleukaemia	...	...	...	11	—	—	2	—
12.	Diabetes	...	...	...	22	2	—	3	—
13.	Vascular Lesions of Nervous System	...	...	...	467	13	19	33	—
14.	Coronary Disease, Angina	...	...	...	607	25	19	34	—
15.	Hypertension with Heart Disease	...	...	...	38	—	2	2	—
16.	Other Heart Disease	...	...	...	337	8	10	17	—
17.	Other Circulatory Disease	...	...	...	120	4	3	13	—
18.	Influenza	...	...	...	33	—	1	1	—
19.	Pneumonia	...	...	...	98	1	1	4	—
20.	Bronchitis	...	...	...	100	2	4	8	—
21.	Other Disease of the Respiratory System	...	...	...	23	—	1	1	—
22.	Ulcer of Stomach and Duodenum	...	...	...	29	—	1	2	—
23.	Gastritis, Enteritis and Diarrhoea	...	...	...	11	—	—	—	—
24.	Nephritis and Nephrosis	...	...	...	12	1	—	1	—
25.	Hyperplasia or Prostate	...	...	...	13	—	—	1	—
26.	Congenital Malformations	...	...	...	29	3	1	1	—
27.	Other Defined and Ill defined diseases	...	...	...	205	6	7	10	—
28.	Motor Vehicle accidents	...	...	...	33	1	—	2	—
29.	All other accidents	...	...	...	74	2	4	—	—
30.	Suicide	...	...	...	11	1	—	—	—
31.	Homicide and Operations of War	...	...	...	—	—	—	—	—

TRATIVE AREAS (1966)

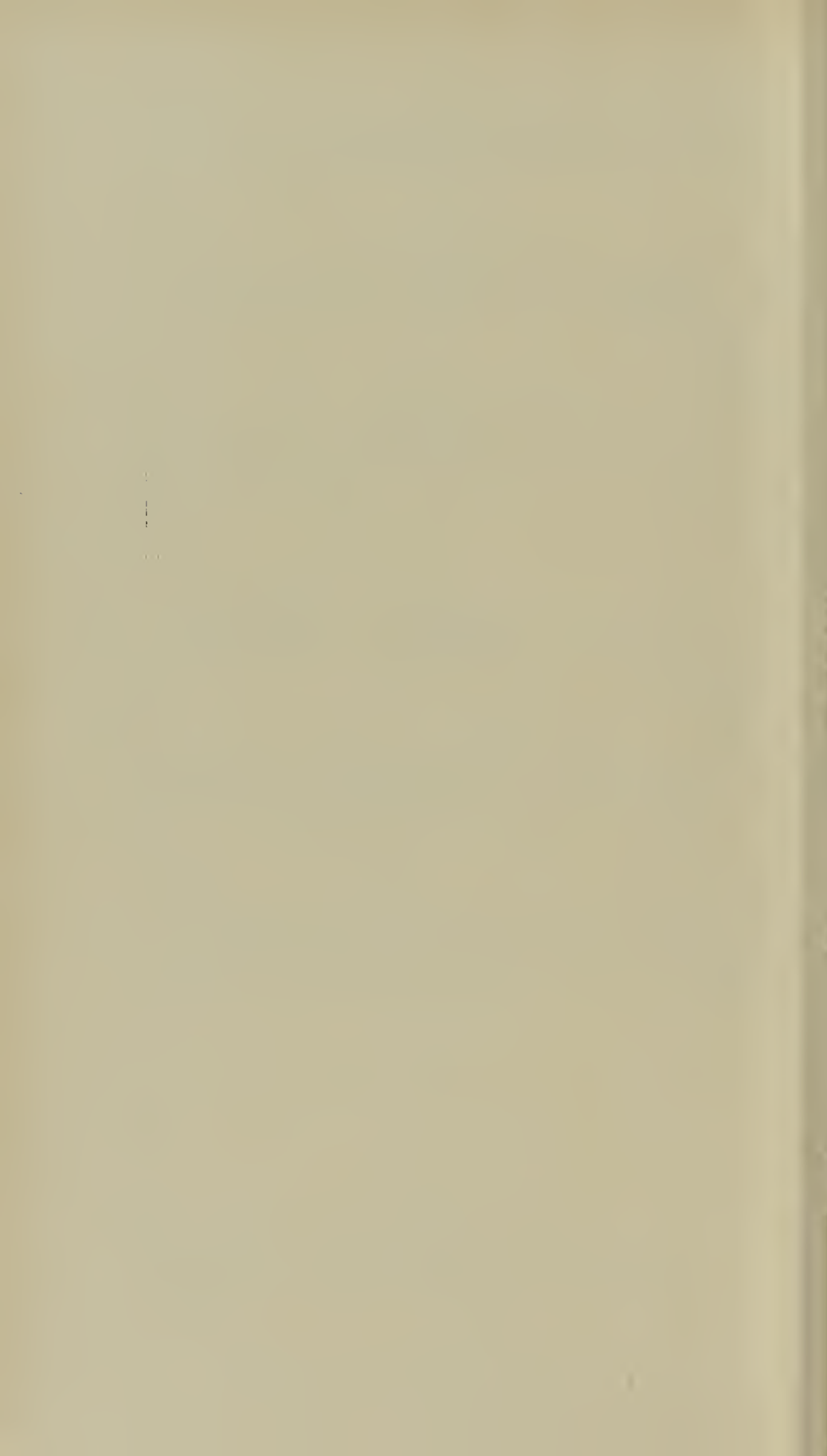
Whitehaven M.B.	Workington M.B.	Aggregate of U.D's.	Alston R.D.	Border R.D.	Cockermouth R.D.	Ennerdale R.D.	Millom R.D.	Penrith R.D.	Wigton R.D.	Aggregate of R.D's.
284	336	1108	23	430	244	356	156	143	301	1653
—	—	1	—	—	—	2	—	1	—	3
—	—	—	—	—	—	—	—	—	—	—
—	1	1	—	—	—	—	—	—	—	—
—	—	—	—	1	—	—	—	—	—	1
—	—	—	—	—	—	—	—	1	—	1
11	9	32	—	6	4	12	3	3	7	35
11	14	39	—	8	6	17	2	6	7	46
6	6	18	1	6	3	1	3	4	4	22
3	2	8	—	1	3	6	1	1	3	15
30	43	127	3	35	17	31	13	15	25	139
2	—	4	—	2	1	2	—	1	1	7
2	1	9	—	—	2	7	1	1	2	13
54	43	196	5	75	49	50	26	18	48	271
52	65	228	1	88	54	81	51	40	64	379
6	3	14	—	7	8	5	1	2	1	24
25	47	128	4	69	26	30	13	18	49	209
2	7	43	2	24	11	15	8	2	15	77
3	7	12	—	3	7	3	1	2	5	21
0	14	32	3	23	9	12	5	5	9	66
0	18	47	—	12	11	16	4	3	7	53
1	1	4	1	2	2	9	—	1	4	19
2	5	11	—	4	2	7	1	2	2	18
—	2	3	—	4	—	2	—	1	1	8
1	1	4	—	1	1	4	—	—	2	8
—	1	3	1	4	1	1	1	—	2	10
—	6	12	—	2	2	6	2	2	3	17
3	26	91	2	27	13	26	13	9	24	114
1	—	6	—	9	5	5	1	1	6	27
3	12	30	—	15	7	6	5	4	7	44
1	2	5	—	2	—	—	1	—	3	6
—	—	—	—	—	—	—	—	—	—	—

MAIN CAUSES OF DEATH



BIRTH AND DEATHS STATISTICS

Year	Estimated mid-year population	Births:		Deaths:		Excess of Births over Deaths
		Number	Rate	Number	Rate	
1916	...	4804	22.1	2968	14.8	1836
1926	...	4337	19.9	2753	12.6	1584
1936	...	3165	15.9	2574	12.4	591
1947	...	4446	22.0	2788	13.8	1658
1951	...	3681	17.1	2827	13.2	854
1952	...	3714	17.3	2603	12.1	1111
1953	...	3608	16.7	2571	11.9	1037
1954	...	3533	16.4	2567	11.9	996
1955	...	3556	16.4	2653	12.2	903
1956	...	3679	16.9	2653	12.2	1026
1957	...	3901	17.9	2640	12.1	1261
1958	...	3834	17.6	2643	12.1	1191
1959	...	3888	17.8	2611	11.9	1277
1960	...	3940	18.0	2629	12.0	1311
1961	...	3900	17.6	2725	12.3	1175
1962	...	4085	18.3	2723	12.2	1362
1963	...	3964	17.7	2813	12.5	1151
1964	...	4147	18.4	2670	11.8	1477
1965	...	3916	17.4	2706	12.0	1210
1966	...	3670	16.3	2761	12.3	909



NURSING SERVICES

Sections 23, 24 and 25 of the National Health Service Act 1946

"It shall be the duty of every local health authority to secure, whether by making arrangements with the Board of Governors of teaching hospitals, Hospital Management Committees or voluntary organisations for the employment by those Boards, Committees or organisations of certified midwives or by themselves employing such midwives, that the number of certified midwives so employed who are available in the authority's area for attendance on women in their homes as midwives, or as maternity nurses during childbirth and from time to time thereafter during a period of not less than the lying-in-period, is adequate for the needs of the area.

It shall be the duty of every local health authority to make provision in their area for the visiting of persons in their homes by visitors to be called "health visitors", for the purpose of giving advice as to the care of young children, persons suffering from illness and expectant or nursing mothers, and as to the measures necessary to prevent the spread of infection.

It shall be the duty of every local health authority to make provision in their area, whether by making arrangements with voluntary organisations for the employment by those organisations of nurses or by themselves employing nurses, for securing the attendance of nurses on persons who require nursing in their own home."



Community Nursing Today and Tomorrow

No part of local authority health and welfare services has been more profoundly affected by the changes in the past year in community medical care, than the Nursing Service. These changes, affecting the form and future of general practice, have been far-reaching. There has been a rapid acceptance of the whole concept of a larger team providing a more effective service and this has included the role of the nurse, the health visitor, and the midwife. Thus the sustained efforts in Cumberland over the past seven years towards full integration of general medical and local authority domiciliary health services have come to maturity at a moment in medical history in this county which is undoubtedly a major turning point. To be commencing attachment to nurses to general practitioner groups now, rather than completing the last stage of the process, is hardly thinkable. As it is the stage is well set for the next forward movement in respect of joint use of premises and the gradual introduction of the general practitioner to all aspects of patient care outside hospital, including child welfare clinic and school health work.

The very rapidity, however, of the recent changes in general practice has brought in train many problems and challenges in securing fully the doctor-nurse team situation—problems of moulding a nursing service to a still changing situation in general practice. This has been noticeable in connection with the combination of some practices to form larger groups and often at the same time involving a shrinkage of practice perimeters. Fortunately these problems are of lesser complexity than their predecessors when the task was one of achieving attachment to small (often single-handed) practices, and at the same time separating as far as possible the nursing personnel of the practices. The new adjustments are often in the direction of simplification. When two practices combine it is obvious that there is immediately a greater flexibility amongst the nursing team. The advantages of combination to the doctors flow similarly to the nurses.

Since flexibility is so important, the advantages in this direction offered by part-time nursing service stand out. It is in this connection that the 'Return to Nursing' clubs described by

Miss Mansbridge on page 73 have proved an invaluable innovation. By this means a ready 'pool' of part-time service has been provided and one which should be readily replenished by new recruits. The members are intelligent, keenly interested young women in whose service in the future I have the fullest confidence. In club and refresher course meetings I have been greatly impressed by their obvious ability and thoughtfulness. At these meetings they contribute widely and deeply to ideas in future developments and progress.

Also, the whole question of establishments is thrown open. To manage this situation with an accurate knowledge of need, and real efficiency, it was clearly necessary to have before one, a day work study of the nurses' activities. An account of this is given more fully in connection with 'Home Nursing' though it embraced health visiting and midwifery also. It is sufficient to say here that the job of some of the home nurses, particularly in rural situations, was less than a full one, whereas those attached securely to more urban practices were more fully occupied. The health visitors, all of whom had a firm general practitioner attachment, were showing signs of being over-taxed in several situations. Midwifery was known already to be a separate and peculiar problem in terms of under-employment, and the special difficulties in this field are described elsewhere in this and previous reports. It would be an over-simplification to say that in Cumberland attachment of staff to group practices had indicated a need for more staff. First of all account must be taken of the greater efficiency produced when practices join together and a team of some 5, 6 or 7 nurses can be welded into an integrated force. Some economy in nursing time must be looked for here, as indeed with medical time. This is emphasised by the planned 'tailoring' of the service by the use of part-time staff. Over against this, however, must be set the fact that some of the economy in doctor-time is bought at the expense of nurse-time; and also the 'discovery' by the doctors of the hitherto unappreciated potential of the nursing team. If there is added to this some service by the nurses to the doctor in the surgery (I say more of this elsewhere) and a beginning of serious health screening of say the elderly on a practice basis, then I have no doubt the establishment needs will creep up. I think I have said enough, however, to indicate that

this must be carefully controlled by operational research and a close watch for areas of possible economy as well as expansion. In Cumberland one of the 'bonuses' from the perplexing domiciliary midwifery position has been some economy in nurse time to be taken up judiciously in home nursing.

I have mentioned the home nurse giving some service in the surgery. Although it is now possible for general practitioners to employ surgery nurses themselves on more satisfactory terms of reimbursement, the advantages to the patient of a more integrated service of home and surgery nursing seems obvious. Already it has been clearly shown in this authority that many patients can attend a surgery or health centre for a nursing treatment who would have previously been visited at home by a nurse. If such a planned approach is going to develop—and I believe it must—I see many benefits from a single team of home/surgery nurses undertaking this. It is, I believe, exactly parallel to the planned medical approach of the doctor who by such means as carefully arranged appointment systems, has been able to arrange his time to much greater advantage. This seems often to include consultation with many more patients at surgery rather than at home. If, in addition to this, the future holds—as again I believe it must—a transport system for rural areas to bring patients to surgeries and so reduce medical and nursing domiciliary visits, then a fully integrated medical and nursing service seems the clear answer. In the few pilot schemes of home and surgery nursing combined, in this county, the arrangements are going with just this kind of 'swing' as envisaged—the nurse with her own 'surgeries' by appointment at the practice premises, seeing cases at home to the minimum extent and continuing treatment at the surgery.

The next two questions which present are—"What is the appropriate training for the 'community nurse' of the future" (including the degree and direction of possible specialisation), and, "What kind of nursing leader should the team have; and what should her qualification and training be?"

With regard to the former question one must assume that health visiting and home nursing will continue as mainly separate tasks in the foreseeable future, except in the most rural areas. On

the other hand the concept of the 'public health nurse' or 'community nurse' whose training and work combine practical and social elements has its attractions and no doubt emerging training schemes will take more account of the social element for the practical home nurse of the future. Fully qualified S.R.N's. many with family experience, coming back into community nursing would probably benefit more from additional social training than from any further extensive courses in what has traditionally been called 'district nursing'. I am sure, however, that the fully trained health visitor will remain in a strong position in the total patient care team—indeed frequently in a leadership position. It is this leadership question within the team which is fascinating at the moment. The need is emerging clearly and the disciplines of administration and, as mentioned above, of social work, seem to be those which should supply the further training for the practice nursing group advisor of the future. The relationship of such key persons to existing area or divisional nursing officers then requires examination and so the whole pattern of nursing administration in the local health authority field. To say this, however, but underlines how incongruous it is becoming to speak of the local health authority field as in any real sense distinct from group general medical practice.

Even when some of the above problems have been further studied and answers suggested, the wider view of group medical practice, embracing other supplementary professions also attached, e.g. speech therapists, physiotherapists, etc., concerns the nursing team. To some extent, of course, the community is following in hospital footsteps here in that the nursing, physiotherapy, social worker etc. components of a hospital out-patient department foreshadow much of the activity of the Health Centre of the future. I have no fear that the nursing team in such a situation will be other than central and fundamental to the practice working.

How far should it be envisaged that nurses in the team should specialise—that is in addition to the existing specialisation of the health visitor towards social work. If, as seems very likely, many doctors in a practice will pursue a special interest, e.g. in obstetrics, paediatrics, etc—how far will they in time look for nurses to work alongside them who have had appropriate special training

and experience? Obviously the availability of nurses with previous specialised experience will influence this; but this also applies to some extent to the doctors. There seems no reason why nurses in a practice team should not acquire the necessary special experience in association with the District General Hospital—or indeed for that matter have continuing connections on a sessional basis with a specialist hospital unit just as some of the general practitioners themselves do.

Perhaps some of these thoughts are not so far removed from the position today as may at first seem. By the time this report's 1967 successor comes to be written, many more dramatic changes may have taken place or at least be on the horizon.

One of the larger group practices in the county in which some of the above mentioned thoughts have begun to see expression in 1966, offers a great potential for truly integrated total patient care in the town which it serves. Working from modern practice premises the many advantages of doctor and nurse teams working in unison are rapidly being appreciated. This is apparent I think from the following report kindly provided by one of the senior partners in the group. He writes—

“The scheme for the attachment of Local Authority nursing staff to group practice started with the advantage that the area is covered by a single group of doctors and there were therefore no problems of nurses having to divide their attention between different practices. Moreover since the group operates from a single central surgery this has provided a focal point where nurses, health visitors and doctors meet in daily contact and, by personal discussion of the medical, nursing and social problems of any patient, can arrive quickly at an agreed and co-ordinated method of dealing with the position. It is this closer personal contact which has been the most satisfying result of the scheme so far.

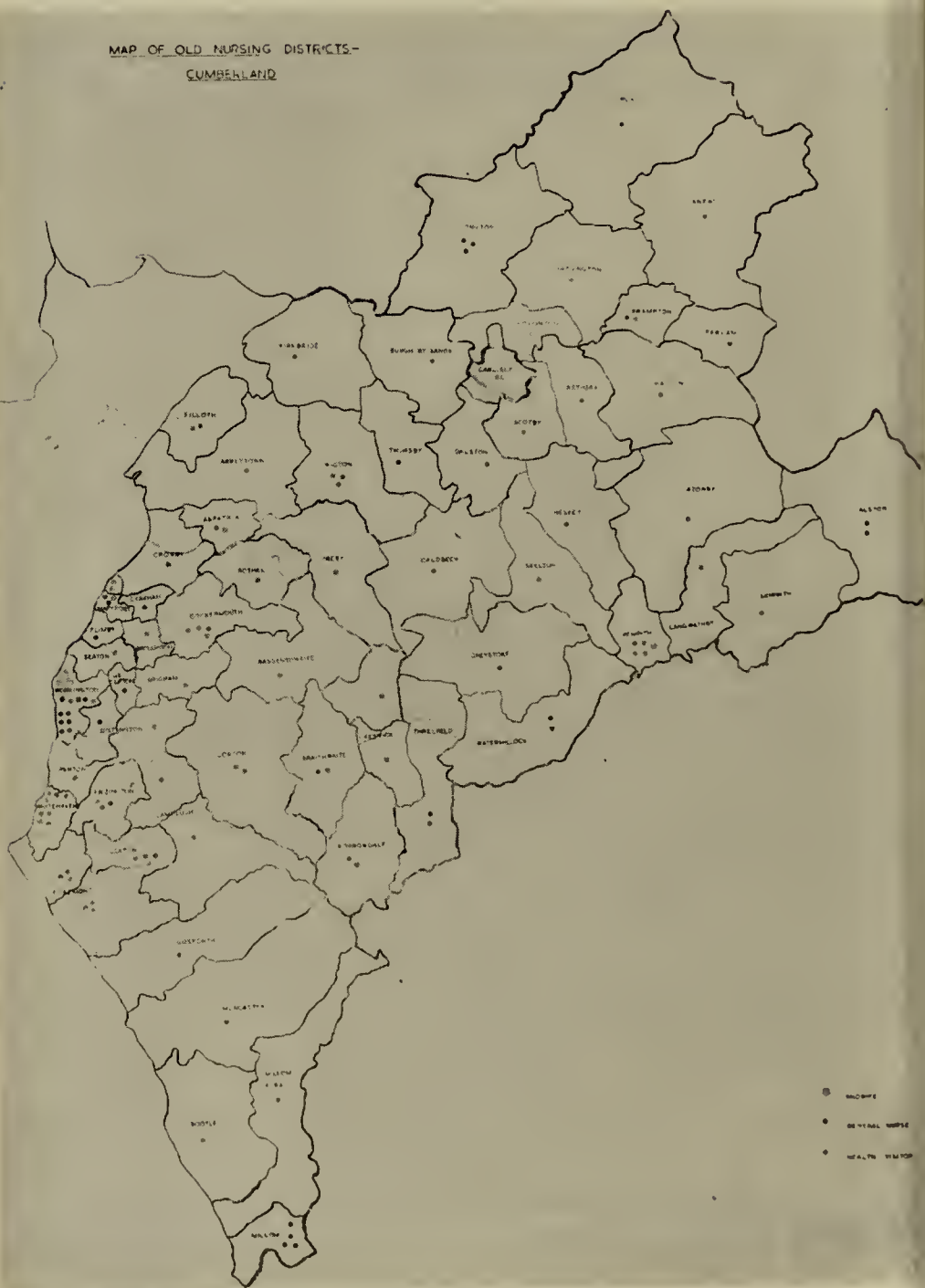
“On the practical side it has been possible to arrange for the nurses to hold daily clinics at the surgery for routine dressings and injections thereby reducing the ‘chores’ which previously took up part of the doctors’ consulting time and also relieving the nurse of some domiciliary visiting. There is in addition the advantage

that if some problem of treatment arises the nurse can immediately get an opinion and advice from the doctor. It has not proved possible to accommodate at the surgery premises the ante-natal and immunisation clinics but these, although held in the Local Authority Clinic, are again carried on by the doctors and nurses working together as a team.

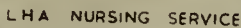
“Initially the potential usefulness of the Health Visitors was not appreciated and the tendency was only to bring them in to deal with para-medical problems which had been discovered by the doctor so that they were being used almost entirely as an aid to treatment. During the past few months there has been a reappraisal of the situation with the realisation that the different approach of the Health Visitors uncovers needs which are seldom revealed to the doctor and they are now being used increasingly to follow up patients, to deal with problems within their province and to advise the doctor of changes in the patients' condition which may need medical attention. This conception of health visitors as an aid to diagnosis has been emphasised by the successful cervical cytology clinics held at the surgery and suggests that one line of development may well be an extension of their part in using 'screening' techniques for the detection of early stages of disease.”



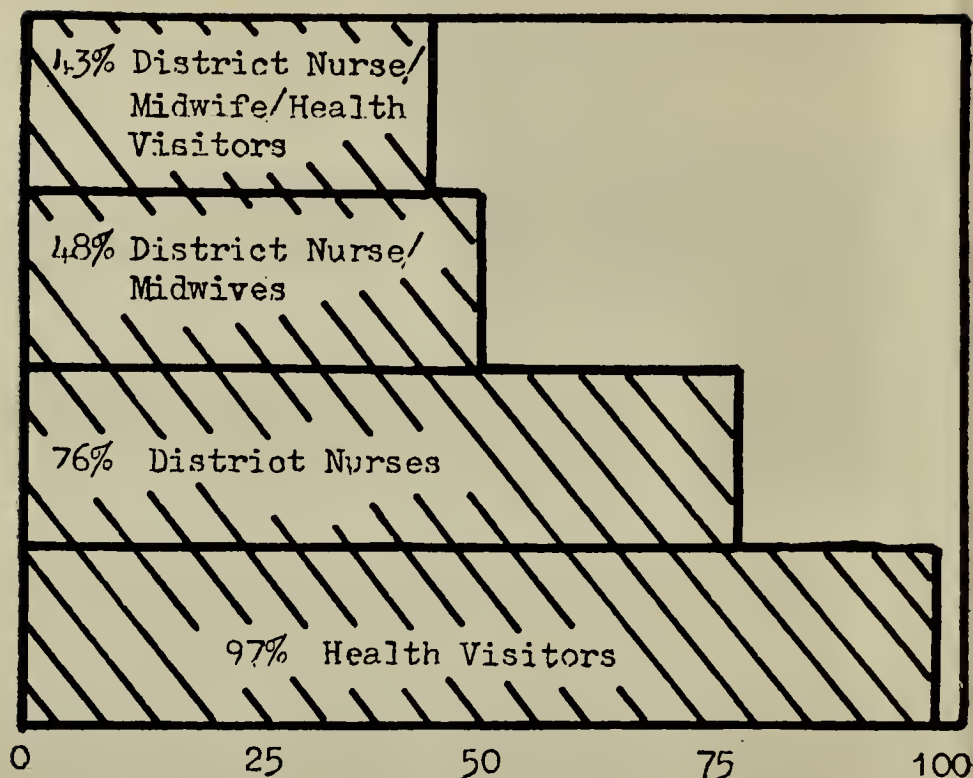
MAP OF OLD NURSING DISTRICTS-
CUMBERLAND



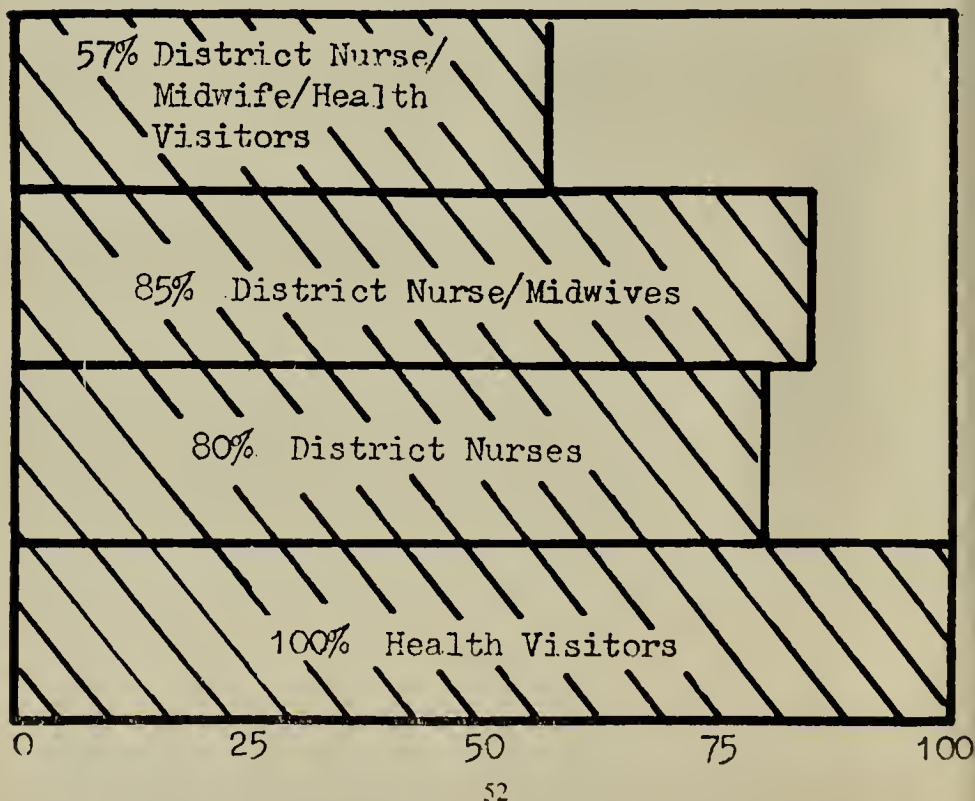
LOCATION OF NURSING STAFF — DECEMBER, 1966



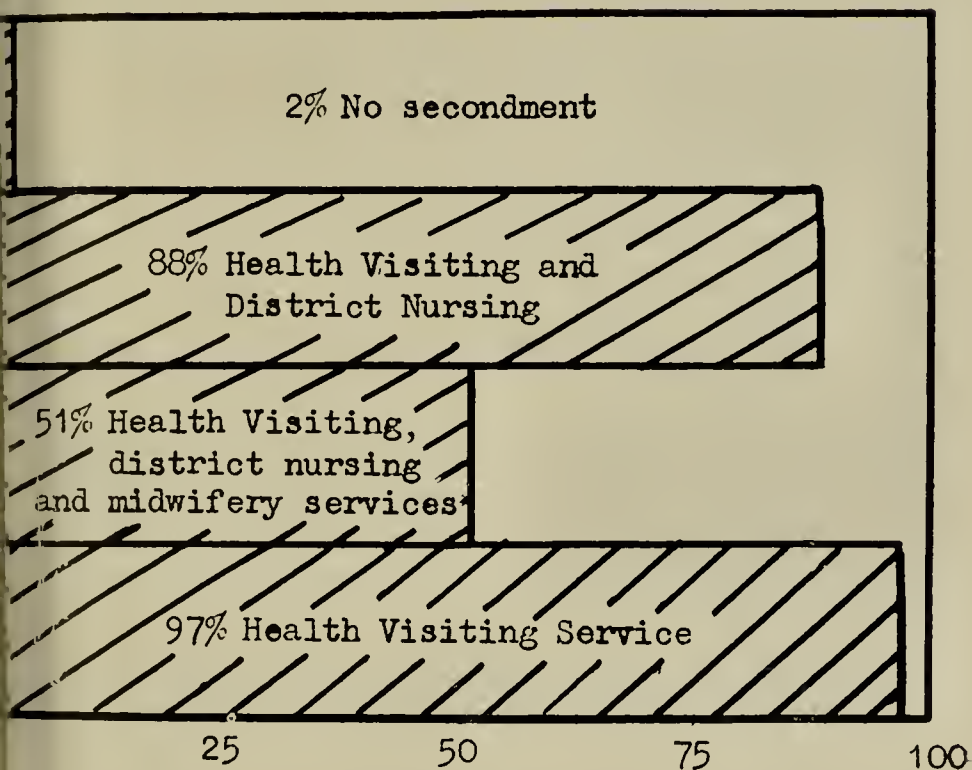
1965 NURSING SERVICES - PERCENTAGE SECONDED



1966 NURSING SERVICES - PERCENTAGE SECONDED



GENERAL PRACTITIONERS - PERCENTAGE WITH SERVICES
SECONDED 1966



MIDWIFERY SERVICE

The downward trend in domiciliary midwifery has continued as previously projected showing this year a drop of 154 domiciliary confinements and a percentage drop of 3%. This decrease has remained constant since the opening of the West Cumberland Maternity Unit and shows without a doubt the influence the provision of maternity beds by a district general hospital has on the domiciliary midwifery service in the area.

Extensive consideration has been given to the course of action which might be followed for the future in order to maintain a midwifery service which would give satisfaction to expectant mothers and midwives alike.

Two main suggestions were put forward: one, that domiciliary midwives might serve both the hospital and the district, and the second, that the domiciliary midwifery might be carried out by the hospitals acting as agents of the local authority. These propositions were for various reasons not acceptable. While mothers retain the choice of having their babies at home, the statutory responsibility remains with the local authority to provide midwives to attend them in the home.

TABLE 1
Live and Still Births

Year		Total Births	Domiciliary	Institutional	Domiciliary Percentage
1954	...	3,594	1,482	2,112	41
1955	...	3,655	1,488	2,167	41
1956	...	3,841	1,584	2,257	41
1957	...	4,029	1,473	2,556	37
1958	...	3,886	1,413	2,473	36
1959	...	3,997	1,324	2,674	33
1960	...	4,046	1,225	2,821	30
1961	...	3,937	1,128	2,809	29
1962	...	4,136	1,148	2,988	28
1963	...	3,996	982	3,014	25
1964	...	4,215	888	3,327	21
1965	...	3,968	711	3,257	18
1966	...	3,719	561	3,158	15

The number of midwives employed in both full and part-time capacity had already been reduced from 74 (in 1963) to 40 in 1966. It has now almost reached a level which causes some anxiety considering the wide geographical area of the county to be covered and the cover required for relief for off duty.

TABLE II

	1958	1959	1960	1961	1962	1963	1964	1965	1966
Domiciliary									
Midwives	78	76	74	66	73	74	69	49	40
Full-time									
Equivalent	46	46	44	39	44	43	22	19	14
Institutional									
Midwives	37	42	42	44	53	55	60	59	50

It must now be accepted that many of the domiciliary midwives will conduct fewer confinements than is ideal for a practising midwife, even though every effort may be made to ensure an equitable distribution of cases between the remaining midwives. Further increase in the percentage of confinements in hospital can only aggravate this situation.

Reorientation of the midwives' duties as a whole must therefore be considered. An extension of attachment to general practitioner obstetricians in the area which the midwife serves would increasingly assist the doctor with his ante-natal and post natal clinics whether for hospital or home booked confinements. A further responsibility would be the organising of a programme of health education (relaxation and mothercraft classes) which would be carried out by the midwife in co-operation with the health visitor.

The increasing number of mothers confined in hospital and discharged after 48 hours to the care of the domiciliary midwife is becoming an important part of her work. As the mother will already be known to the midwife through the general practitioners' ante-natal clinics, a continuity of care will be achieved.

It is envisaged that the midwife could undertake the care of the mother and baby for 28 days. For this a certain amount of training in neo-natal care of infants in the first month of life would be necessary. An interesting and comprehensive job should emerge which would give satisfaction to the midwife and a continuity of care for the mother from doctor, midwife and health visitor together.

The installation of short wave radio in a limited number of midwives' cars as a pilot scheme was under discussion for some months in 1966 but was not able to operate until February, 1967. It was decided to fit radio-telephones in three cars in each area as follows: Northern Area covering Silloth, Wigton and Kirkbride; Western Area covering Workington, Cockermouth and Maryport; and the Southern Area covering Whitehaven, Ennerdale and Seascale. The midwives concerned were consulted and demonstrations of the technique required were given to them at the ambulance stations. Written instructions were issued and each midwife was given her code identification.

The results up to the time of writing have been very encouraging. In the Northern Area there have been several instances when a midwife was required in the middle of the morning, and by the relatives telephoning the ambulance station the call was relayed to the midwife who was at the house in a very short space of time. It is hoped that installation of a radio call-out system may be extended to all practising domiciliary midwives in the near future. It obviously gives both patient and midwife a sense of security which is not available by any other means.

Cases 'At Risk'

During the year 64 mothers were booked for home confinement who were considered to be in the high risk group. Although the number has been reduced by 20 since the previous year there are still some who prefer to accept the risk of a home confinement although there is every indication that confinement in hospital would be for the greater safety of mother and child. The reasons for refusing admission are mainly family ones—not wishing to leave the children. Early discharge after 48 hours is offered to all who

feel reluctant to be confined in hospital but this is not always accepted. Of the 64 'At Risk' booked cases it is noted that 48 were delivered at home, 16 in hospital, 8 of these were transferred to hospital in the ante-natal period (of whom 1 mother unfortunately died at 25 weeks gestation from asthma and complications), 8 were transferred during labour.

The results of the confinements were:—

Stillbirths	...	...	...	3
Miscarriages	...	...	...	1
Live Births	...	...	...	59
First week death	...	...	...	Nil
7-28 days deaths	...	...	...	2 babies

The fact that there has been some reduction in the number of high risk cases booked for home confinement must not be allowed to obscure the very serious situation which still exists in connection with this group. The perinatal mortality rate for these 64 mothers who were booked for home confinement, and should by all the best obstetric standards have been booked for hospital, is 47 per thousand live and still births, compared with an overall figure now of 26.8. This should be sufficient to underline the seriousness of mothers having unsuitable arrangements made for their confinements. The claim that these mostly occur on the insistence of the mother herself is not acceptable as a complete answer by any means. This is a matter of the combined efforts of doctor and midwife in educating mothers into a rational and safe attitude to their own confinements. It is a very black spot on the history of this subject in 1966, that a maternal death actually occurred in this group of mothers. Overwhelming tragedies like this in a family must be prevented at all costs today.

Midwives who notified their intention to practise in the county during the year numbered 120. These included six whole-time midwives working in urban areas three of whom were concerned with Part II midwifery training, 43 district nurse/midwives and 70 midwives working in maternity hospitals or maternity units of small hospitals. One midwife working independently notified her intention to practise attending one confinement only in a private capacity.

Medical help was sought by the midwives according to the rules of the Central Midwives Board on 36 occasions. This is almost the same number as last year. The doctor is booked in nearly all cases and a medical aid form is now used only when an emergency arises during the period from the patient booking the midwife to the end of the puerperium.

Ante-natal Period—

Early rupture of membranes	...	...	...	1
Toxaemia	...	...	...	5
Postmaturity	...	...	...	1
Prematurity	...	...	...	1

During Labour—

Post-partum Haemorrhage	...	...	...	2
Ruptured perineum	...	...	...	5
Mal presentation	...	...	...	1
Delayed delivery	...	...	...	3
Precipitous labour	...	...	...	1

During Puerperium—

Mother—

Pyrexia	...	...	...	...	...	3
Phlebitis	...	...	...	...	...	1
Sore throat	...	...	...	...	...	1

Baby—

(a) Asphyxia	...	...	...	...	...	3
(b) Sticky eyes	...	...	...	...	...	7
(c) Discharging ear	...	...	...	...	...	1

During the year the midwives paid 10,205 visits to patients confined at home and in addition paid 2,101 visits to 463 patients discharged from hospital before the tenth day. As there are sufficient midwifery beds to ensure each mother ten days' stay in hospital early discharge is not encouraged, but is acceded to when specially requested, or for a specific reason.

Health Education for expectant mothers was a subject discussed in detail at the Maternity Liaison Committee for both East and West Cumberland, and the following points were considered as essential, in order to extend the health education programme.

1. Regular exchange of information on the subject between midwives, health visitors and the general practitioners to whom they are seconded.
2. Diligent follow up of these mothers for attendance at classes.
3. Increased publicity in clinics and general practitioners surgeries where acceptable.
4. The establishment of small groups or individual teaching in the patient's homes or nurses' houses in rural areas.
5. The establishment of evening classes in appropriate situations.
6. Information to be available regarding hospital booked patients who could attend classes locally other than the hospital.
7. Increased use of voluntary workers to look after toddlers while mothers attend classes.

The implementation of this programme has not been as satisfactory as expected and a review of the year's work showed some drop in numbers. The hospital midwifery staff stated about 50% of mothers attended classes but, although everything was done to encourage mothers to attend, there were still those who were not interested. It was felt the united efforts of midwife, general practitioner obstetrician and consultant obstetrician might help in this without too much pressure being put on the mother who does not wish to attend.

Ante-natal clinics are held as formerly in local authority clinics and in the doctors' and nurses' surgeries and during the year 545 expectant mothers, booked either for hospital or domiciliary confinement attended, and 5,932 ante-natal visits were paid to expectant mothers at home, which includes 2,132 visits for educational purposes. A considerable amount of health education is done both through mothers attending mothercraft and relaxation classes held in the various clinics and also by individual visits to mothers at home who live in isolated areas and are unable to attend classes. A total of 359 mothers attended the midwives' classes, with 2,054 attendances.

All these mothers are hospital booked patients. It is difficult to assess the actual percentage of all mothers receiving health education and attending relaxation classes, but from the domiciliary angle this is certainly not more than one-third, which shows the necessity for further development in this work.

The replacement of the gas and air machine by the new gas and oxygen Entonox machine is in progress and this year three of these machines have been purchased. Most midwives also have trilene machines and there are still a few gas and air machines in use.

The problems of continuing the Part II midwifery training in co-operation with Workington Infirmary have become even more acute owing to the shortage of cases in the present domiciliary midwifery situation.

Each pupil midwife must spend three months 'on the district' under the supervision of an experienced domiciliary training midwife approved by the Central Midwives Board for this purpose. Each of the pupils must conduct at least ten deliveries in the home and the position has now been reached where the domiciliary midwives concerned with the training have themselves such a reduced number of cases that it is scarcely possible to provide the necessary number for the pupils. This causes great concern both to the pupil and the midwife who feel the training is hardly adequate. The following table gives details of the position to date:—

TABLE III**Part II Midwifery Pupils Trained on District**

Year		No. Pupil Midwives	No. Midwives approved for training	No. of confnements by these midwives
1962	...	12	3	260
1963	...	8	3	179
1964	...	10	3	166
1965	...	6	3	127
1966	...	8	3	103

A maximum number of pupils demands a total of at least 120 domiciliary confinements and more are really necessary to allow of cases being 'missed' due to off duty and lecture periods.

Several meetings with the West Cumberland Maternity Liaison Committee and the hospital staff concerned have, been held throughout the year without a satisfactory conclusion to this problem being reached. Some modified form of training must be devised and put to the Central Midwives Board for consideration.

The position really is that by the expansion of the facilities for hospital confinement, the hospitals have sounded the death knell of Part II Midwifery Training on, and for, the district as we have known it hitherto.

The loss of a Part II Training School, associated with West Cumberland Hospital, would not in practical terms affect the local authority domiciliary midwifery service to any great extent since our needs for midwives is now very small. Obviously the importance to the hospital service in terms of recruitment etc. may be much greater and it is to be hoped that a modified training scheme can be arranged with the approval of the Central Midwives Board. This same situation will very soon catch up with many other areas of the country. Cumberland is probably one of the first counties to feel embarrassed by the lack of domiciliary

confinements but with the expansion of hospital accommodation other areas will quickly follow suit and there will be a general lack of satisfactory Part II Training Schools.

If the present pattern of Part II midwifery training continues the situation will arise where midwives are being trained for a domiciliary service which will become literally non-existent. Consideration of the future training of the midwife is of the utmost importance and should be considered as a national responsibility.

Post Graduate Course.

Miss Blockey, Deputy Superintendent Nursing Officer, attended a refresher course for supervisors of midwives, in London, in April. The syllabus covered all aspects of the supervisor's work and lectures on a wide field of midwifery were given by various consultant obstetricians and gynaecologists.

Miss Blockey reports: "It was interesting to hear other people's thoughts on administration and the qualities that are seen in good administrators. We all felt we fell short of the ideal. Were we as leaders encouraging effort and drive? Did we raise the morale of the staff? Were we stimulating and did we live in mutual trust and security with the staff? We were all surprised to hear that an average of 12% of employees in all spheres of life were problems".

Eight domiciliary midwives attended statutory courses arranged by the Royal College of Midwives at Durham, Hull and Bradford. They all appreciated the opportunity to hear the latest advances in midwifery and to meet midwives from other parts of the country and compare notes on current trends in the work in different areas.

The local study days arranged by both East and West Cumberland Branches of the Royal College of Midwives give opportunities for midwives from hospital and the local authority to meet together and the valuable help given by the consultant obstetricians through their lectures is much appreciated.

HEALTH VISITING

It is no exaggeration to say that the health visiting service in Cumberland has been transformed over the past 5-6 years. From being a competent and conscientious body of highly trained nurses, it has become a professionally integrated group with the general practitioners of the county. All function more effectively and purposefully since the whole work is based on a much deeper insight into the needs of those served. In the most mature health visitor/general practitioner relationships, the health visitor herself is accepted as a professional colleague with a special and invaluable contribution to make to the work of the practice. It has been most gratifying to follow the progress of the various attachment schemes up to the present point where all health visitors have an attachment, and the most recent schemes are developing up quickly as general practice regroups and reorganises. The health visiting service in this county has been the pioneer of integrated and total patient care outside of hospital, and health visitors may well be proud of an achievement of far-reaching importance. Certain interesting items of detail follow upon this great change in the health visiting service. One interesting one is the matter of uniform—should the health visitors any longer wear uniform? Doctors visiting homes do not wear uniform, nor do social workers, etc. The day is past when the health visitor requires such an official form of accrediting to families. She is part of the practice team and visits the home as a colleague and to some extent a representative of the doctor. It is interesting to note that the majority of health visitors in this authority have now come to the conclusion that uniform should no longer be worn, and arrangements are going ahead at present to discontinue this practice. I believe this is a perfectly natural part of the evolution of this extremely important medico-social service.

There has been an increase of 5 full-time health visitors, and 1 part time during the year, all of whom are attached to general practices. This compares with a situation of 92% attachment in the course of 1956. The nurses undertaking district nurse/midwife/health visitor duties have been reduced from 14 to 6, only one of whom does not hold the health visitor's certificate but continues to

hold the dispensation for this work granted by the Ministry of Health. There are also two health visitor/district nurses and one health visitor/midwife, all fully qualified.

The establishment of health centres where possible will be expedited as and when local conditions allow. Who will be included in the team of workers, and what size of population will they serve? It would seem units of 12—16,000 would be a reasonable working and economic population to cover in a rural county. The professional staff of some 6 or 7 general practitioners with health visitors, district nurses, midwives, social welfare workers, home helps and ancillary staff would work together as a team. How and where does the health visitor fit into this conception? She is a key worker in the field of prevention of illness. Holding as she does the additional qualification of the health visitor's certificate she is well qualified to assume additional responsibility. She is in a unique position in working with all age groups, the children, the parents, and the elderly, living in normal surroundings, and she is able to assess a situation when there is deviation from the normal.

I have already referred earlier to the clear need for a nursing group adviser in the team associated with a group practice or health centre. This person's work would be partly administrative in co-ordinating the work of the nursing team to the maximum advantage of the practice. No doubt in many cases one of the health visitors attached to the practice or centre will quite naturally become the group adviser. Health visitors are in a strong position here, although I would not envisage the group adviser necessarily always having the health visitor qualification. I am sure it can be said confidently however, that the individual who is "group adviser material" would, in most cases, enhance her competence by having the health visitor qualification.

Three student health visitors completed their training and were appointed to Brampton, Kirkbride and Workington, all attached to general practice.

The following table shows the number of home visits to children under five years of age:—

Year		No. of children under 5 years of age visited during the year	First visits to children under 1 year of age	Total visits to children under 5 years
1964	...	17473	4039	61866
1965	...	16949	3899	57367
1966	...	16013	3462	53073

There is a reduction in the number of home visits to children under five years; I do not feel this is of any particular significance as more children are seen at the doctor's surgery than ever before and there is not the same necessity for routine visits to the home. The attached health visitor knows better than ever before which of her mothers need extra guidance and individual help in the home

In addition, 11,105 visits have been paid to persons over 65 years of age. This compares with a figure of 10,239 in 1965—the figure for 1964 was 9,631. This is clearly therefore an increasing commitment and the health visitor is frequently able to arrange for help to be given either through the Home Help Service, Meals on Wheels or any other supportive service which may be required. In certain instances the co-operation of the physiotherapist has been arranged in order to ensure the patients on leaving hospital have had the correct continuity of rehabilitation in their own home to enable them to keep fully mobile. This allows a person to continue to live alone provided the supportive services are made available.

It is very evident from the many reports received that the health visitors have very wide contacts in their work and undertake a considerable amount of health education to all groups of the population. This is enlarged upon on the section on Health Education.

The health visitors continue to operate the cervical cytology service in the clinics and the district nurses and midwives the domiciliary service. Further reference to this is made elsewhere in the report.

Miss Jackson, a health visitor attached to a general practitioners group at Workington, looks to the future and writes as follows:—

“It is over eighteen years since the National Health Service Act came into operation.

“There have been changes in the economic and social conditions since then, and it is right that from time to time existing medical and social services should be reviewed, old and by now impracticable functions discarded, and new ideas introduced.

“As a Health Visitor I am naturally interested in the changes that will eventually come about and how this will affect the work of the profession.

“In the past the image of the Health Visitor was at the ‘baby or clinic nurse’. This concept has disappeared, and her duties are now wider and more varied.

“This is in part due to the attachment of the Health Visitor to the Family Doctor Practice. We find that we are now part of ‘the team’ with an increasing call on our services

“There are more visits to the elderly, and the Doctor often uses the Health Visitor as the link with the Welfare Department regarding the provision of the Home Help, admission to Part III Accommodation and the Convalescent Home. Inevitably, at present, there is some overlapping in the work of the Health Visitor and the Welfare Officer in this particular field.

“In the not too distant future it seems possible that the Family Doctor and Local Authority Staff will work as a team from a well-equipped centre. The closer personal contact and saving in time should make for a more efficient community service.

"I am of the opinion that Health and Welfare Departments cannot be completely separated. Most social problems have underlying mental or physical ill-health or handicap.

"Nor do I think that the Health Visitor can be divorced from social work. More social studies are in fact included in the new syllabus for Health Visitor training.

"Legislation states that the Health Visitor has a duty to visit certain groups of people in their homes. It is because of this access to the home that the Health Visitor has the advantage over the specialist social worker, who is frequently not called in until a serious situation has developed. As part of the Family Doctor team and with her nursing background she is also well accepted.

"A routine visit to a home by the Health Visitor does on occasion uncover a problem. It could be associated with the prospect of an illegitimate child and its subsequent welfare, or marital strife, or disharmony between grandparent and adolescent living in the same house. It could be information regarding the neglect or ill-treatment of children, the inability of parents to cope with a handicapped child, or the behaviour problems of another child.

"Some of these problems can be overcome by the families themselves, given time and a little support. Some need to be referred to workers more qualified to deal with them.

"In conclusion I would suggest that there could be a more personal contact between all departments. At present we meet infrequently, usually for the purpose of discussing some particular problem family."

A very successful refresher course for Local Authority and Hospital Staff was held from March 27th—April 1st, at Underscar Guest House, Keswick, situated in a very pleasant position with wonderful views of the mountains and Lake Derwentwater from the windows. The theme throughout the course was "Communications" and included days devoted to the subjects of psychiatry, paediatrics, and geriatrics, a day on communications common to hospital and local authority and on the last day a general summing up of the whole course.

A very good representative group of 35 nursing staff attended which included administrators from both fields of nursing, hospital ward sisters and local authority field workers. Mrs. E. G. Cain, O.B.E., J.P., Chairman of the Health Committee, welcomed everyone and the opening address was given by Dr. J. J. A. Reid, T.D., County Medical Officer of Health, Northamptonshire, who outlined the growth of public health work and how the problems of the past have played their part in securing benefits which have had far reaching effects up to the present day.

Dr. M. Sackwood, Administrative Medical Officer, Newcastle Regional Hospital Board, spoke on the role of the hospital board, giving a comprehensive picture of the hospital pattern in the region. Other speakers were Miss E. M. Watt, Regional Hospital Board Nursing Officer, and Miss E. M. H. Johnston, Regional Public Health Nursing Officer, Ministry of Health, talking on "Communications" in their special fields of nursing care. "Communications in Psychiatry" was introduced by Dr. W. V. A. Erskine, Consultant Psychiatrist, Garlands Hospital, in a most helpful and stimulating speech, and was followed by the general practitioner's point of view by Dr. J. O'Donovan, general practitioner from West Cumberland. Dr. J. Kaminski, Consultant Geriatrician West Cumberland Hospital, spoke on the "Modern Patterns for the Care and Rehabilitation of the Elderly", a vast subject which ranged from the elderly patient at home, through his rehabilitation in hospital to a state of independence and his return home. Dr. H. A. Fleming, a general practitioner from Whitehaven, followed speaking on statistics and their use in general practice.

"Communications in Paediatrics" by Dr. J. W. Platt, Consultant Paediatrician, West Cumberland Hospital, took us through the child's development and communications with his mother, with the mother and the nurse and family doctor. Dr. J. M. Kirk, general practitioner, Ravenglass, followed up this theme in his address.

During the week films were shown and visits paid to hospitals and local authority centres, also to the Outward Bound Mountain School, Ullswater. I am indeed grateful to all who helped to make the course a success.

Students visiting the Health Department

Throughout the year there has been a continuous number of students visiting the health department for experience in the domiciliary services, both health visiting and nursing. First, those student nurses who are training for State Registration at the Cumberland Infirmary and the West Cumberland Hospital, and the pupil nurses who are taking the State Enrolled Nurse training at the City General Hospital, Carlisle or at Workington Infirmary. These students spend a day visiting patients in their own homes with the home nurses who are attached to general practice. This gives them some insight into the home conditions to which patients return, and how treatment can be continued just as efficiently at home.

Secondly, the State Registered Nurses who are taking either district training or health visitor's training; they come from all parts of the country e.g. Salford, Stockton, Warrington, Gateshead, the former for three days' experience of work in a rural area and the latter for a week of health visiting in a rural or semi-urban area. This year we have arranged experience for 57 hospital students, 8 district nurse students and 12 health visitor students from Bolton Health Visitors' Course. This is quite a formidable number and I am most appreciative of the help given to these students by the nursing staff working in the field.

Senior nursing personnel attending the course on Community Health Administration at the William Rathbone Staff College, Liverpool, from Leicestershire and West Suffolk have visited the county for one week's experience in nursing administration. Miss Lewis, Director of Public Health and Hospital Nursing Services, Newfoundland, also spent two days with us. All were particularly interested in the development of the attachment of nursing staff to general practitioners and enjoyed meeting all concerned with this aspect of work.

HOME NURSING

There is absolutely no doubt whatever that a well run group practice with full nursing staff attachment pays high dividends to the patients, doctors and nurses alike. This is especially so when one or more of the nursing staff attend the surgery. One has only to visit a busy surgery to see how the well oiled wheels run; the patients' waiting time, by the appointment system, is negligible; the nurse and health visitor are available on the spot to co-operate with the doctor and patient on the various problems that arise; be it for a child under school age, a school child or the elderly person requiring supportive help from one of the local authority services. A tremendous amount of work is accomplished in a short space of time with satisfaction to everyone concerned.

Re-organisation on these lines has been integral in the development of the home nursing service in the county and each year shows progress and an awareness of the advantages which accrue to those involved. Indeed some of the general practitioners have been so encouraged as to ask like Oliver Twist 'for more'—in this case nursing staff!

The study in home nursing in six areas recently undertaken by the Queen's Institute of District Nursing and published under the title 'Feeling the Pulse' revealed some surprising things. It had been generally assumed that every doctor knew the nurses with whom he worked but this was not found to be so and this alone highlights the importance and necessity of the attachment of nursing staff to general practitioners whether in single or group practices.

There are now 8 nurses undertaking surgery work for general practitioners at Millom, Workington and Maryport and this will shortly start in Seascale. Accommodation for a nurse's surgery is not always possible for the nursing staff and may delay the extension of a scheme until suitable arrangements can be made.

Home Nursing

	Total number of persons nursed during the year	Aged under five at first visit.	% of total cases nursed.	Aged 65 or over at first visit	% of total cases nursed.	Malignant Disease	% of total cases nursed.	Remaining cases	% of total cases nursed.	Total Number Nursing Visits
1962	5696	381	7%	2893	51%	237	4%	2185	38%	117,648
1963	6083	455	7%	2933	48%	248	4%	2447	41%	125,266
1964	6167	448	7%	2966	48%	285	4%	2468	41%	134,305
1965	6105	433	7%	3059	50%	279	5%	2334	38%	150,656
1966	6159	276	4%	3479	57%	284	5%	2120	34%	161,984

Miss Young, who has now had the opportunity of combining her home nursing with a morning session in the surgery for a full year gives the following report:—

“The community care of the patients of the practice to which I am attached continues to be most interesting and satisfying. The feeling of being a member of a team has become more obvious due to the increased knowledge of the organisation of general practice and the medical, family and social problems of the patients with which I am involved.

“I now hold six sessions for treatment per week in the surgery and the work is increasing. Many patients with lacerations, abscesses, burns etc. can be treated, who previously would have been sent to either Workington or the West Cumberland Hospitals. This is of great benefit to the patients and minor operations are undertaken in increasing numbers.

“Cervical smears are taken from patients recommended by the doctors and from the ‘well women’ who prefer to come to the surgery.

“Surgery work combined with district work is very worthwhile. The majority of patients I attend at home are over 65 years of age and the surgery patients include babies, children and the younger age group so that I feel I am helping all age groups in the population, and thus make good use of both my children’s and general hospital training which I hope is to the benefit of the patient.”

“The staff situation changes each year, less in the actual number than in the categories in which they work. There are now 30 nurses engaged full time in home nursing and 16 part-time, an increase of 1 full-time and 5 part-time during the year. In addition there are 26 district nurse/midwives, 6 district nurse/midwife/health visitors and 1 district nurse/health visitor whose duties include home nursing, thus making a total of 30 full-time home nurses and 49 having a part-time commitment. There are very few who do not have some form of attachment to general practice. The histogram above shows the progress made in this way during the year.

Return to Nursing Clubs

The first meetings of the above clubs were held in Carlisle, Workington and Whitehaven in September, 1966, and have been held each month since then.

It was felt that owing to the early marriage of many nurses, some during their training, there must be a potential source of part-time nurses available, as yet untapped. It is also well known that nursing in hospital which demands a 24-hour patient cover is not always compatible with the times available by the married nurse who has her family responsibilities. Why should the domiciliary nursing service of the local authority not offer employment which would fulfill a need both for the nurses and the authority?

With this in mind the establishment of the clubs was advertised widely in all the local papers, inviting application on the form provided. The response was immediate and over a period of about six weeks enquiries were received from as far afield as Lancashire, Dumfriesshire and Westmorland totalling 180 and of these 137 completed enrolment forms and wished to join a club.

Although no plan had been made as to how to run the clubs it was very soon apparent that the members themselves wished to meet on a professional basis rather than just for a social occasion. They were very keen to be brought up to date on all the recent nursing developments, particularly in the care of children and the elderly.

With the expansion of the attachment of part-time nursing staff to general practitioners in the county it was felt it would be useful to arrange a programme which would include speakers from the various departments of the local authority services and the following programme was devised for each of the clubs, the speakers not necessarily being the same person in each area:—

Medical Officer of Health—Public Health—Social Medicine.

Nursing Officer—Domiciliary Nursing Services of Today.

Welfare Services Officer—The Handicapped, the Inadequate and the Elderly in the Community.

County Ambulance Officer—The Modern Ambulance Service
Social Welfare Officer—The Modern Approach to Mental
Health.

Consultant Paediatrician—Advances in Paediatrics.

General Geriatrician—Care of the Elderly.

General Practitioner—Working together at a Team.

Area Medical Officer—Interesting Facts and Figures.

Assistant Director of Education—Present Trends in Education

In addition to the monthly meetings, a short intensive course of one day from 10 a.m. to 2.30 p.m. each week for six weeks was held at Whitehaven Further Education College during November and December. Thirty nurses who had intimated their availability for part-time work with the local authority enrolled. The course was very well attended by a most enthusiastic group and already one or two have since taken up nursing appointments. The total number of members returning to nursing work up to the present time is 18; 10 to district nursing, 2 to school nursing and 1 to surgery work, 2 survey work for the elderly, 1 for mentally handicapped and 1 to private nursing and 1 health visiting.

There is no doubt therefore that the clubs are fulfilling a need, both in the availability of nursing personnel for part-time work and in the satisfaction of the nurses themselves meeting together professionally when there would otherwise be little, if any, opportunity for this.

It is my hope that the clubs will continue to expand and that new members will join to replace those who leave.

In studying the numbers of patients nursed, and visits paid, it is found that they continue in much the same way as in former years, showing an increase of 420 in the number of patients over 65 years of age nursed at home and a decrease of 157 in the number of children under five. There is an increase in the total number of all patients nursed at home of 54, and of total visits paid including surgery treatment of 11,328. This I consider a satisfactory expansion for one year.

Survey of Nurses' Work

Reference was made to this in the previous year's Annual Report and as the survey at that time had not been completed it was left over to this year for the final assessment.

In a county of this size with a scattered population it was found that travelling takes up quite a considerable amount of time each day for all nursing staff, averaging about $1\frac{1}{2}$ hours a day.

The main points which have emerged from the survey are nurses undertaking general work spend about half their time in actually attending patients, their average working day being 6 hours 56 minutes; district nurse/midwives spend about two-thirds of their time with their patients and their average working day is 7 hours 9 minutes; the average working day of the full-time midwives is the lowest (5 hours 4 minutes) due to the gradually diminishing domiciliary confinements and the low incidence of patients discharged after 48 hours; district nurse/midwife/health visitors spend about half their time with their patients, average working day 7 hours 42 minutes. The survey shows there is more clerical work mainly in connection with health visiting.

The health visitors' average working day is 7 hours 40 minutes—they spend more than half their time with all categories of the population whom they meet in the course of their work. Health visitor's visits to general practitioners in their surgeries average 20 minutes per day.

The survey has shown that the general nurses could do more work through attachment to general practitioners and attendance in their surgeries, which would be to the benefit of doctor, patient and nurse; this is already operating in some areas and will no doubt be developed as and when surgery accommodation is available by consent of the general practitioner or through the local authority clinic or health centre.

Re-organisation of the midwifery service is already in progress and full-time midwives will have their duties expanded as mentioned elsewhere in the Report.

The health visitors' work is constantly under review in the light of increased attachment to the general practitioner.

It is intended that the survey should be undertaken at least once each year; this will show the trend of the work undertaken by the nursing staff as new concepts are put into operation.

It is essential for the nursing staff to keep up to date in modern trends in nursing and to appreciate the importance of community care and liaison with the hospital service. This is done by liaison with the ward sisters and charge nurses in the hospitals particularly with the care of geriatric patients and in the children's wards. Opportunity is also afforded for a proportion of the staff to attend Post Graduate Courses arranged by the Queen's Institute of District Nursing. Three of the staff attended a course in Liverpool and three in Bristol. Lectures were given on the Problem of the Cancer Patient, the Cardio-vascular Patient, Geriatric Care and Research in Nursing to mention but a few of the subjects. The stimulation of attending a course where nurses from all over the country meet together to discuss their problems is very evident from the reports received on their return.

Staff meetings are held quarterly, and group meetings more frequently, in each area and special speakers arranged. We are indebted to Mrs. Williamson, consultant obstetrician, East Cumberland, and Mr. Cockersole, consultant obstetrician, West Cumberland, for speaking on the problem of Family Planning. Mr. Smith, County Ambulance Officer, brought the nurses up to date with the developments in the Ambulance Service.

Marie Curie Memorial Foundation Day and Night Nursing Service.

This service has now been operating for a full year. It had a very slow start and indeed can never be said to have reached any speed in development as only 8 cases have been helped during the year, 3 in the northern 2 in the western and 3 in the southern areas. Nevertheless I feel that if only one or two patients suffering from cancer, and their relatives, can receive some practical help

at a time of great stress it is well worthwhile continuing the scheme. On enquiry it was found that for the size of the population and in comparison with other areas the demands were about average. Financial help is available in the form of a grant to patients requiring assistance for such things as bed linen, clothing, extra diets, fuel etc., 10 patients have been helped in this way during the year.

Laundry Service

The laundry service in the Whitehaven area, run in conjunction with the West Cumberland Hospital laundry, has developed this year and is now used more frequently. It is certainly a great help to the relatives of incontinent patients; 95 were helped by this service during the year. Incontinence pads continue to be used and are in constant demand as also are the protective pants which are a great boon to the ambulant but slightly incontinent patient.

Voluntary Organisations

The voluntary organisations are most active in their help with the domiciliary services and one of the most practical ways is through the help given by the members of the British Red Cross Society in organising the distribution of the loan equipment, available for use by patients at home.

They are entirely responsible for the administration of the depots in Carlisle, Workington and Whitehaven.

With the rehabilitation of geriatric patients there is an increasing demand for the loan of commodes and at times the problem of supplying these becomes temporarily acute. Demands for the smaller appliances can be met easily but wheelchairs are in particular demand during the summer months and at times there is again a temporary shortage.

I am most appreciative of the time and effort put into the running of these depots through this Voluntary Service.

District Nursing Training

The district nursing training scheme has continued and this year five nurses who had been appointed to the staff took the training. The practical work was undertaken in their own area and the three weeks' block theoretical period at the Training Home in Liverpool. Miss Blockey, Deputy Superintendent Nursing Officer, is the tutor to the course, arranged tutorial classes and visits of observation to other services connected with the work.

I much appreciate the co-operation received from the Liverpool Corporation Health Department Training Scheme in assisting us in this way.

20 Years progress in the Nursing Services

Approaching retirement, the Superintendent Nursing Officer, Miss I. Mansbridge, M.B.E., writes:—

“The past is inspiring, the future is challenging and the present is our responsibility. These words have an added significance when one is about to hand over the present responsibilities after a period of 20 years in the county. Although ‘forward looking’ is the watchword of today it is important to look back in order to put things in perspective and to pay tribute where it is due.

“When I came to the county in 1947 the Cumberland Nursing Association was about to celebrate 50 years of work. It was also facing a crisis through the take-over of all domiciliary nursing staff by the County Council through the implementation of the National Health Service Act.

“As I leave, a new era is being established with the formation of health centres which emphasises the community care of the patient and the coming together of all members of the domiciliary team concerned with the care of the patient, whether in the prevention of illness, the maintenance of good health or the rehabilitation after illness.

“In a quiet way, Cumberland has through the ages shown a pioneering spirit in the development of its nursing services. It began in 1897 when the Cumberland Nursing Association was formed “to employ nurses to relieve the sick and suffering in their own homes”. It was one of the earliest counties to do this and was managed by a voluntary Committee of ladies and gentlemen who had the well-being of the people at heart and agreed to form local district nursing associations to raise funds to pay the salaries of the nurses and to equip them to the best of their knowledge and ability. The Association immediately affiliated to the Queen Victoria Jubilee Institute for Nurses later the Queen’s Institute of District Nursing, thus setting a standard for its future work and development. The nurse’s work gradually expanded to include not only general nursing and midwifery but school nursing and health visiting particularly in the rural areas, and more nurses were required. The financial situation was difficult, depend-

ing as it did in the early years on voluntary subscriptions and the Provident Scheme; later grants were received from the Ministry of Health through the County Council for midwifery and health visiting. There were times, however, when there was insufficient in the funds to pay the nurse's salary at the end of the month: an embarrassing situation for all concerned.

"In 1947 the Cumberland Nursing Association had to face a tremendous upheaval, a new era was in sight which forecast the end of the voluntary committees of both the county and local district nursing associations. While they were glad to be relieved of financial anxiety they were much concerned how the 'take-over' by the County Council would affect the people. Would it be to their advantage and would the personal touch be lost? These and many other questions were considered in detail. I feel a tribute should be paid here both to the pioneers and members of the voluntary committees who by their foresight, work and generosity undoubtedly laid the foundations of the domiciliary nursing services and by whose inspiration the county was enriched. The pioneer nurses too, whose devotion to duty and care of their patients was quite remarkable, deserve a special mention. They cycled long distances in all weathers and they attended very ill patients without having the advantage of modern drugs and antibiotics which are common today and their hours of duty were long and salaries and transport inadequate.

"With the implementation of the National Health Service Act the financial difficulties were eliminated and it was possible to extend and develop the nursing service and to arrange for state registered nurses to take district training prior to appointment. From 1948 onwards great progress was made in providing houses and cars for nurses improving equipment and arranging adequate off duty. Salaries also improved through negotiations by the Whitley Council.

"There was however little change in the actual plan of the work. The health visitor worked on her own with very little contact with the family doctor, the nurses worked in their circumscribed areas, nursing the patients of all doctors in their area. Some lived in very isolated places having little contact with their

colleagues, apart from staff meetings, or with general practitioners except by telephone or by prior arrangement for meeting usually at a patient's home.

"Since 1960, with the development of attachment of nursing staff to the general practitioners a new concept of working together as a team has emerged, and working in isolation is a thing of the past.

"The picture is not yet complete but reports from doctors, nursing staff and patients indicate an interest and enthusiasm in developing the work along these lines, which when in full operation will be to the benefit of all. The regular meeting together, the interchange of records and above all the fact that the patient links the doctor, the health visitor and the nurse as working together as a team from the same place gives an added confidence.

"There is undoubtedly a challenging and interesting time ahead for those who follow on, and I wish everyone success in their endeavours. Throughout the years I have always had the co-operation of the nursing staff and a tribute must be paid to those both in administration and in the field who have given me such loyal support and have been so helpful, particularly in accepting the changing pattern of their work, in the present decade.

"I am deeply grateful to the County Medical Officers of Health with whom I have worked, Dr. Kenneth Fraser, O.B.E., M.D., the late Dr. W. H. P. Minto, M.D., and Dr. J. Leiper, M.B.E., T.D., and am most appreciative of the advice, help and support they have always most willingly given."



HOME HELP SERVICE

Section 29 of the National Health Service Act, 1946

“A local health authority may make such arrangements as the Minister may approve for providing domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, aged, or a child not over compulsory school age, within the meaning of the Education Act, 1944”.



HOME HELP SERVICE

Life is moving at an increasing rate each year and the developments in the Home Help Service both nationally and locally keep pace with it.

The only signs of slowing down are those which are obvious among the elderly recipients of this service. As they grow older their movements and responses are slower and more help is required to enable them to continue to live comfortably at home; this of course is the main responsibility of the Local Authority in the provision of a home help service.

Area	No. of Home Helps	No. of Households assisted
Northern	117	384
Western	54	469
Southern	71	448
	242	1301

An increase of 127 households helped during the year.

The Ministry in issuing Circular 25/65 at the end of that year asked for a statement of the authority's intentions by June 1966. This led to a review of the service, consideration being given to all its aspects including an assessment of local needs, problems of recruitment and in-service training for the staff.

Of necessity local needs have always been considered as has been shown each year by the difference in the number of staff required in the Northern area as against that of the Western and Southern areas. The former, due to its larger geographical area, about equal to the other two areas together yet has an almost similar population. It has more isolated villages and requires double the number of home helps most of whom are part-time. Recruitment continues on the whole to be satisfactory. An acute shortage in one place one day may be resolved and the situation back to normal within a short space of time. There are still certain areas in the county where it is difficult to recruit permanent staff. This is mainly in the Lake District National Park and the

Fell villages of the Pennines; also one of the more urban areas, Penrith, has periodic difficulty due mainly to the high number of households requiring help. The very rural areas are now more adequately covered by the provision and use of two Mini vans. The one allocated to the Western area has operated for a full year, the second van supplied in July, was placed in the Northern area. In each area two home helps, both of whom are drivers, travel together thus co-ordinating the transport and enabling them to help twice the number of households in any one day with a minimum amount of travelling time and personal fatigue, facts which justify the expense of the vans.

	Western Area Jan.—Dec.	Northern Area July—Dec.
Mileage	7964	3087
Home Helps	2	2
Households helped	20	11

Mrs. Hewetson and Mrs. Johnston, two home helps who share the use of the van in the Northern area, write as follows:—

“To be a home help is a job which brings great satisfaction and some comfort to many aged people. Without the mobile van which we now have in the fellside area of east Cumberland many homes could not be visited. The area is very scattered covering the villages of Ousby, Skirwith, Culgaith, Langwathy, Glassonby, Lazonby and other small hamlets. In many of these isolated villages ‘buses are few and far between and sometimes the homes we visit are often two or three miles from the ‘bus stop, and without the van many valuable hours would be taken up in travelling.

The average miles we cover each day are approximately 40; we are visiting 5 homes per day. At present we are working in households quite closely together and in some we work together which means we can move on more quickly to the next house.

Many of our elderly householders are without any electrical equipment so the Hoover supplied for our use has brought many a laugh and many a criticism. Some find it too noisy but we wouldn’t like to be without it, also the other useful equipment

provided with the van. We enjoy our work and much appreciate having the van to help us."

Mrs. Garrett and Mrs. Hewitt, two home helps in Western area write:—"The Home Help van in the Western Area has completed its second year of service. The value of this van has again proved itself by the wide range of places we have been able to cover, such as Keswick, Troutbeck and Buttermere, which could only have been covered by means of this transport. The van has stood up well to the rough farm roads and gives complete satisfaction all round."

An increasing number of home helps have their own cars which they are willing to use. They are then able to save travelling time and provide easy contact between two or more villages which are not served by a local bus service, thus visiting two or more households in the same morning becomes possible.

In-service training for Home Helps apart from a residential course for 25 home helps in 1964, had not been proceeded with until this year when it was decided to hold a course in each area one day a week for four consecutive weeks to take place in June and July, in Carlisle, Workington and Whitehaven.

The theme was Community Care of the Elderly and while the content of the programme was the same in each area the speakers were varied. It was designed to give information concerning all the services available for the elderly, whether provided by the hospital, the local authority or the general practitioner, and speakers from each branch of the service took part.

The hospital service contributed in no small measure by providing speakers from both medical and nursing staff and by making possible useful visits of observation to the geriatric wards both in the City General Hospital, Carlisle, and in the West Cumberland and Whitehaven Hospitals.

A general practitioner in each area gave a very useful talk on the problems which arise in caring for the elderly in general practice and how they can best be met. Members of the county nursing staff explained their part in the care of the elderly and matrons of welfare homes arranged visits of observation.

There is much help and co-operation given to many aspects of work for the elderly by members of the voluntary services and the method of operation was explained by members of both the Women's Royal Voluntary Service and the British Red Cross Society covering Meals on Wheels service, home visiting, loan equipment, aids for the handicapped to mention but a few.

The 76 home helps and 24 attendants from the welfare homes who attended the course all expressed their appreciation and pleasure in being invited to meet together for such an interesting and helpful purpose, which gave them a feeling of belonging to a team of essential workers. Interesting accounts were received from home helps in each area and the following is an extract from a report sent by four home helps in the Western area:—

"The first of a once-weekly four-day home help refresher course was opened at Salterbeck clinic by Dr. J. L. Hunter, Western Area Medical Officer. In welcoming us to the course he hoped we would enjoy it and find some useful instruction on how to help and care for our senior citizens.

"The first speaker was Dr. J. Kaminski, Consultant Geriatrician at the West Cumberland Hospital. His talk was most interesting and revealing, stressing the importance of encouraging old people to help themselves. Instead of doing everything for them we ought to coax them to do little jobs that would keep their interest and keep them active.

"Later in the course we had the opportunity of visiting the geriatric unit in the West Cumberland Hospital and the Whitehaven Hospital Day Centre where we met some of the patients. Dr. Kaminski's interest in them and their confidence in him was quite remarkable.

"Mr. McGeorge, Charge Nurse in the geriatric ward, West Cumberland Hospital, told us all about the care and rehabilitation of the patient in hospital and how their aim was to get them well enough to return home. Relatives were encouraged to visit the hospital and find out for themselves how much a patient could do, so that the activities could be continued at home and so prevent deterioration.

"Miss Hall, Senior Welfare Officer, gave us a very interesting talk on the welfare services that are available to the elderly in our county. She showed us very colourful slides of the homes and flatlets and when we later visited Richmond Park, we met some of the residents we had seen on the slides and we felt we were meeting old friends. Miss Ross, Matron of Parkside, Maryport, gave an enlightening and amusing talk on the problems of the elderly living together in a residential home.

"The second day opened with a talk by Mrs. Steele, Area Nursing Officer, mainly on the day to day problems in the work.

"Miss Blockey, Deputy Superintendent Nursing Officer, followed with a very helpful talk on the prevention and treatment of accidents, including a list of foods we should encourage old people to eat which would give a simple, balanced diet.

"Dr. Grant, a general practitioner from Workington, gave us a clear picture of ways in which we could help the elderly. He stressed the importance of keeping them happy in their own homes and giving them a positive job to do as a practical way of helping to preserve their faculties.

"The third day was opened by Miss Mansbridge, Superintendent Nursing Officer, who outlined the changes taking place both nationally and locally, in the health services and how the home help fitted into the team. Mr. Cowham, Welfare Officer, then spoke on the scope of his work and the difficult task of handling the confused elderly, and made us very aware of the care they need. His talk provoked many questions as it was obvious we had all had contact with these people at one time or another. Mrs. Sanderson of the W.R.V.S. and Mrs. Sterne of the B.R.C.S. spoke on their work in running the Meals on Wheels service, home visiting and aids for the handicapped.

"The final and fourth day of the course was opened by Miss Mansbridge speaking again this time on the responsibilities of the home help and all it entails, stressing particularly that each one of us must work as a member of a team. If we wish our work to be successful we cannot work in isolation. Mrs. L.

Messenger spoke on her work as a District Nurse and showed us the contents of her nursing bag, which has to be seen to be believed. Miss A. Jackson, then outlined her work as a health visitor which was most interesting. She explained how our work was of great value to her and that she very much appreciated our co-operation as indeed did Mrs. Messenger.

"To conclude the course, a panel of speakers, under the chairmanship of Dr. Hunter, answered questions which we sent in beforehand or asked during the meeting.

"Community care is a wonderful expression. It would be good to see posters on this in bright, eye-catching colours or stickers for cars—much better than a "tiger in your tank" or "stickin' bullet holes!" The course has clearly pointed to the fact that the care of the elderly and handicapped is not only the concern of the health service, Red Cross, W.R.V.S. and other organisations known for their good works and on whose kindness and interest so much depends, but it is also the business of "the man in the street" and of the children who are now aware of the need for service".

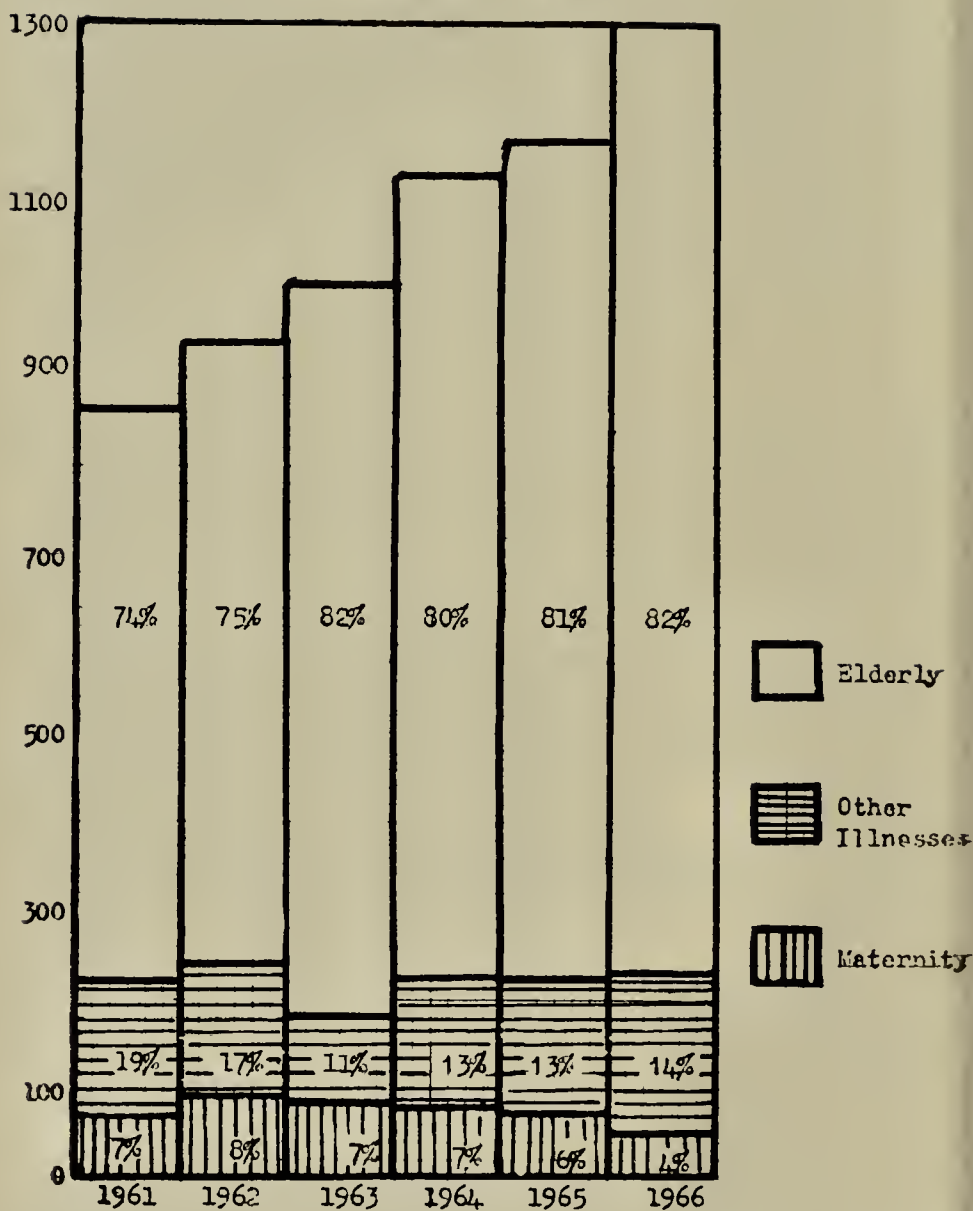
This summary was compiled from reports received from Mrs. E. S. Coyd, Mrs. D. Foster, Mrs. M. Bainbridge and Mrs. E. Fraser.

The family help service for families in special difficulties has not made any spectacular progress this year. There continues to be the sporadic need for help and guidance in these families with special problems and the need is met when it arises. This year three families have been helped but not all entirely successfully. In one household the difficulties were such that it was more than the home help could manage even with all available supportive help.

There has been very little demand for implementation of the arrangement whereby the charges might be waived in supplying a home help immediately to a household when the mother requires complete rest due to toxæmia of pregnancy though the wheels can be put in motion to arrange immediate help if required.

With the advent of health centres in the foreseeable future and the development of attachment of staff to general practitioners, all working from a health centre I envisage the home help as a member of that team each centre having an allocation of home helps to work in the area. The home help will then be in much closer contact with all the personnel who help the elderly and she will feel a true member of the team.

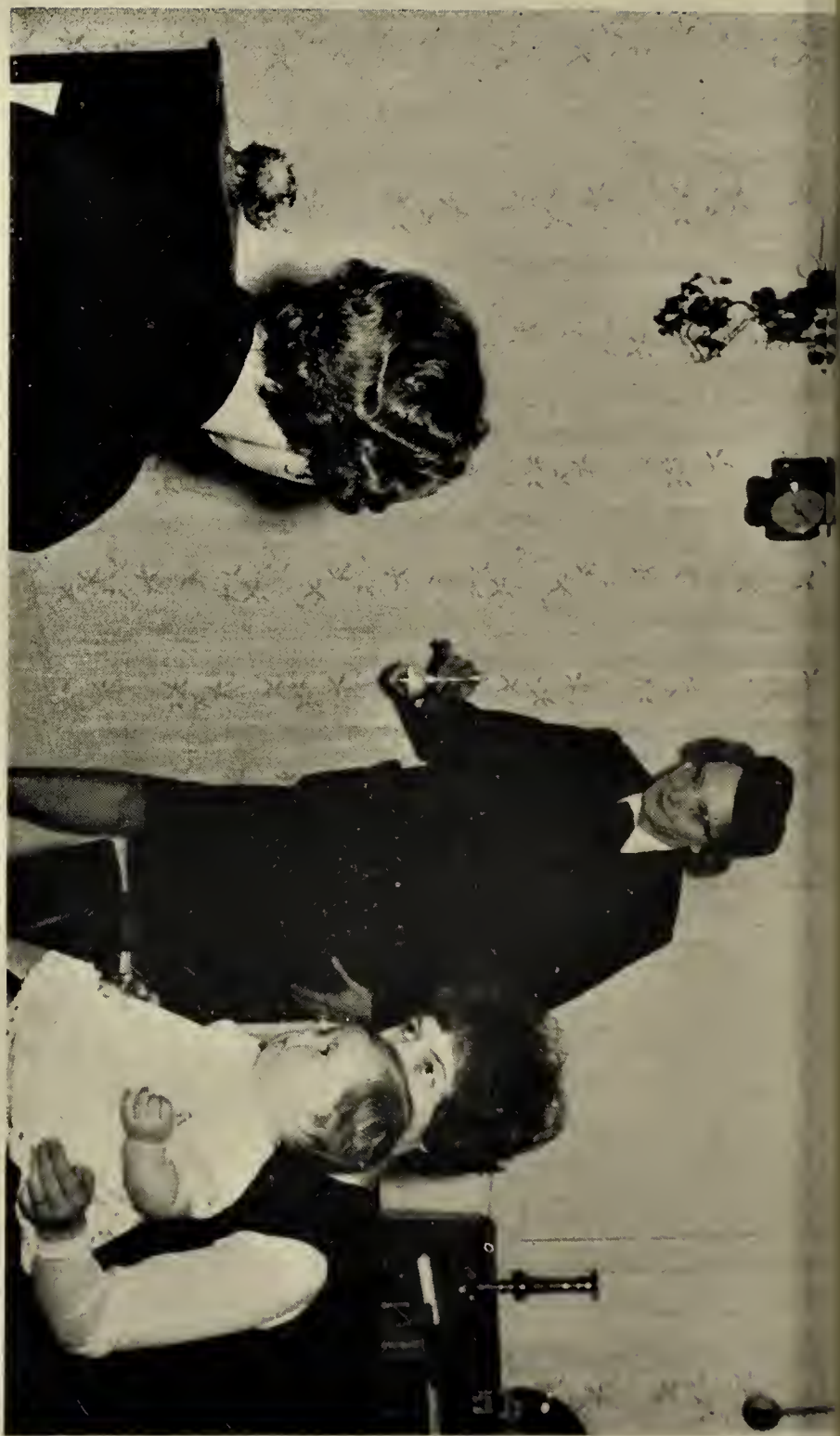
HOME HELP CASES



CARE OF MOTHERS AND YOUNG CHILDREN

Section 22 of The National Health Service Act, 1946

“It shall be the duty of every local health authority to make arrangements for the care, including in particular dental care, of expectant and nursing mothers and of children who have not attained the age of five years and are not attending primary schools maintained by a local education authority”.



CAN BABY HEAR ?

CARE OF MOTHERS AND YOUNG CHILDREN

The whole concept of the care of mothers and young children as a separate section of local authority responsibility under the National Health Service Act, reflects in its own way the developing history of health services. The way in which mothers and young children have been and are regarded as a special group with particular risks has changed perceptibly. This is mainly associated with the 'stop-gap' type of service which the local health authority has had to provide in the past which could not reasonably be provided any other way. This applies to such matters as welfare foods, and also to larger issues such as child welfare clinics. The latter, however, as I indicate elsewhere in this report, have now reached a stage where they should clearly be in the hands of the family doctors, and so the care of mothers and young children becomes increasingly absorbed into the developing pattern of total patient care in the community. It is also interesting to notice in this connection Mr. Neal's reference to the volume of dental care in this group which is given by general dental practitioners and the pleasing degree of co-operation and integration there is with his own department. All of public health nursing and such matters as health education, and vaccination and immunisation, weave into this unifying picture of health care in the community.

Statistics

The perinatal mortality rate continues to fall and to approximate more closely to the national figure. Representing the number of stillbirths and first week deaths per 1,000 live and stillbirths, this index has lost nothing in its deep significance. Further reference is made to this with regard to midwifery services and to the work of the two Maternity Liaison Committees in the county. The fact must be stated and restated that the ultimate elimination of home confinement of high risk cases would undoubtedly be the next most significant single contribution to an improved perinatal mortality rate.

Some attention has been given by the West Cumberland Local Maternity Liaison Committee in particular to the high rate of perinatal deaths caused by congenital malformations. This is

certainly much higher than in many parts of the country and is being studied at present with the help of the Registrar General and colleagues in other authorities. There is certainly a fascinating field of study here in terms of the wide regional variation in this particular cause of foetal and infant death. It is interesting to note that if Cumberland's rate for this particular cause was nearer to the national figure our overall perinatal mortality rate would be significantly below the national.

The general distribution of the causes of perinatal deaths (shown in Table on page 98) shows no very significant variation from recent years. In general it is probably fair comment to say that, although still further efforts must be made for high risk cases to be confined in hospital, the perinatal mortality rate has reached a level at which slight fluctuations might soon appear from year to year, rather than an unbroken steady annual reduction.

Year	Stillbirths	Early Neonatal Deaths	Perinatal Deaths	Stillbirths per 1,000 total births		Perinatal deaths per 1,000 total births	
				Cumberland	E'land & Wales	Cumberland	E'land & Wales
1956	...	64	175	29.3	22.9	46.2	36.7
1957	...	64	166	25.5	22.5	41.5	36.2
1958	...	69	149	20.4	21.5	38.1	35.0
1959	...	54	137	20.9	20.8	34.5	34.1
1960	...	60	171	27.4	19.8	42.2	32.8
1961	...	53	129	19.1	19.0	32.4	32.0
1962	...	71	149	18.7	18.1	35.8	30.8
1963	...	69	136	18.8	17.2	33.7	29.3
1964	...	47	124	18.2	16.3	29.4	28.2
1965	...	37	117	20.0	15.7	29.3	26.9
1966	...	40	100	15.9	15.4	26.9	26.3

Analysis of Causes of 100 Perinatal Deaths During 1966

Cause of Death	Stillbirths			
	Premature	Full-time	Deaths during 1st Week	Total
Toxaemia	5	3	4	12
Antepartum haemorrhage	2	2	1	5
Placental insufficiency	6	—	1	7
Rh. with antibodies	2	2	—	4
Maternal Diabetes	—	—	1	1
Prematurity	4	—	17	21
Congenital malformation	10	3	4	17
Tentorial Tear	1	1	1	3
Asphyxia—	—	—	—	—
(1) Prolapse of cord	—	—	—	—
(2) Cord around neck	—	1	—	1
(3) Intra uterine	3	2	2	7
(4) Pneumonia (inhalation)	1	—	1	2
(5) Anoxia	1	2	2	5
Atalectasis	2	—	3	5
Congenital heart disease	—	—	1	1
Cerebral Haemorrhage	—	1	—	1
No known cause	3	—	—	3
Pneumonia	—	—	2	2
Mal presentation	—	—	—	—
Maceration	2	1	—	3
	42	18	40	100

Infant Mortality

Cause of death	Age in weeks			Total
	Under 1	1 to 4	4 to 52	
Toxaemia	4	—	—	4
Prematurity	17	—	—	17
Congenital malformations	4	6	4	14
Asphyxia	—	—	4	4
Atalectasis	3	—	—	3
Pneumonia and bronchitis	2	4	4	10
Congenital heart disease	1	3	3	7
Cerebral haemorrhage	—	1	1	2
Meningitis	—	3	—	3
Gastro enteritis	—	—	—	—
Other causes	9	2	2	13
	40	19	18	77

The comparative rates of infant deaths per 1,000 total live births for Cumberland together with England and Wales are as follows for the period 1956 to 1966:—

Year		Rates per 1,000 total live births	
		Cumberland	England and Wales
1956	...	30.4	23.8
1957	...	26.4	23.1
1958	...	28.2	22.5
1959	...	21.1	22.2
1960	...	23.1	21.8
1961	...	22.6	21.4
1962	...	26.4	21.7
1963	...	22.0	21.1
1964	...	18.3	19.9
1965	...	16.9	19.0
1966	...	21.6	19.0

Notification of Congenital Abnormalities

During the year 45 notifications were received making a total of 176 notifications for the three years since the inception of the scheme by the Ministry of Health. The malformations were classified as follows:—

			Males		Females		Live Births	Total Still Births
			Live Births	Still Births	Live Births	Still Births		
Total cases notified	...	...	74	10	68	24	142	34
Central nervous system	...	...	12	9	15	22	27	31
Eye, ear	...	...	1	—	1	—	2	—
Alimentary system	...	...	9	—	10	1	19	1
Heart and great vessels	...	...	4	—	3	—	7	—
Respiratory system	...	...	1	—	1	—	2	—
Uro-genital system	...	...	13	—	—	—	13	—
Limbs	...	...	28	—	28	—	56 +	—
Other skeletal	...	...	2	—	1	—	3	—
Other systems	...	...	1	—	—	—	1	—
Mongolism	...	...	2	1	7	—	9	1
Other malformations	...	...	1	—	2	1	3	1

+ includes 30 notifications of talipes

Of the total of 176 cases notified during the three years approximately 19% were stillborn and of the 34 stillbirths all but three were from malformations connected with the central nervous system.

The number of female stillbirths during the three years from malformations of the central nervous system was 24 from a total of 34 cases notified (70%) and there were 10 male stillbirths from similar causes from 20 notified (50%).

Hospital confinements during the year under review accounted for 85% of the total births and all children born in the major maternity hospitals were seen by a consultant paediatrician.

It is of interest that on the inception of the scheme by the Ministry in 1964, for the recording of all instances of malformations apparent at birth, that the rate per 1,000 live and stillbirths for Cumberland was 15.4 compared with a national average of 16.1.

The comparative rates in 1965 were England and Wales 15.5 and the County of Cumberland 16.5. The overall rate for the County in respect of the three year period 1964 to 1966 is 14.77 and a rate of 12.1 is returned in respect of the notifications received during 1966.

Prematurity

A premature infant is a live born infant with a birth weight of 5 lbs. 8 ozs. or less, or with a period of gestation of less than 37 weeks.

The percentage of premature live births of total live births increased from 5.2% in 1965 to 6% in 1966.

Premature births notified during 1966 are set out below with the 1965 figures for comparison.

1. Number of premature live births notified:—	1965	1966
(a) in hospital	196	218
(b) at home	17	22
(c) in private nursing homes	—	—
	207	240

2. Number of premature stillbirths notified:—		
(a) in hospital	51	34
(b) at home	3	3
(c) in private nursing homes	—	—
	54	37

There was a total of 10 premature babies born at home during 1966 compared with 11 during 1965; of these 10 all survived.

Premature Live Births

Weight at Birth	Born in Hospital			Born at home or in a Nursing Home Nursed entirely at home or in a nursing home				Born at home or in a Nursing Home Transferred to Hospital on or before 28th day				Premature Stillbirth Born		
	Died			Died				Died						
	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	Total Births	Within 24 hours of Birth	In 1 day and under 7 days	In 7 days and under 28 days	In hospital	At home or in a Nursing Home
1. 2 lbs. 3 ozs. or less ...	(1) 7	(2) 6	(3) —	(4) —	(5) —	(6) —	(7) —	(8) —	(9) 1	(10) 1	(11) —	(12) —	(13) 3	(14) —
2. Over 2 lbs. 3 ozs. up to and including 3 lbs. 4 ozs.	14	8	1	1	—	—	—	—	1	—	—	—	7	1
3. Over 3 lbs. 4 ozs. up to and including 4 lbs. 6 ozs.	50	10	1	1	1	—	—	—	2	—	—	—	9	1
4. Over 4 lbs. 6 ozs. up to and including 4 lbs. 15 ozs.	50	—	1	1	—	—	—	—	2	—	—	—	9	—
5. Over 4 lbs. 15 ozs. up to and including 5 lbs. 8 ozs.	97	1	—	—	9	—	—	—	6	—	—	1	6	1
6. Total	218	25	3	3	10	—	—	—	12	1	—	1	34	3

Care of the Unmarried Mother and her Child

During the year, the County Council accepted financial responsibility for the financial maintenance of 42 cases and, in addition, continued its financial support to the Diocesan Councils by making direct annual grants.

The number of cases which, as in previous years, were referred to the County Council by the Moral Welfare Associations, was markedly less than in 1965 and are more comparable with the years 1964 and 1962.

Admission arrangements to the homes are made by the case workers of the Social and Moral Welfare Associations in the area. The period of financial responsibility is normally for a total of 12 weeks, six weeks prior to and six weeks after confinement, extensions are however accepted in special circumstances.

The following table gives a break-down of the ages of the mothers who were accommodated during the year and also gives comparative figures for the previous five years:—

Age			1966	1965	1964	1963	1962	1961
13 years	...	...	—	—	—	1	—	—
14	...	...	—	—	—	1	2	—
15	...	...	—	1	4	3	3	1
16	...	...	3	6	3	—	5	3
17	...	...	10	6	4	2	4	5
18	...	...	5	13	5	3	7	2
19 — 24	...	...	18	31	21	12	12	22
25 — 30	...	...	4	2	1	7	4	1
31 plus	...	...	2	1	3	2	1	1
TOTAL			42	60	41	31	38	35

The Mother and Baby Homes to which the mothers were admitted are shown hereunder, together with the actual number of admissions to each home. The figure in brackets indicates the average number of patient days resident after confinement.

Coledale Hall, Carlisle	...	...	20 (30)
St. Monica, Kendal	...	...	16 (44)
Brettargh Holt, Kendal	...	...	3 (51)
Other Homes	...	...	3 (32)
			—
			42
			—

When considering these figures one should I think, have regard to the overall situation. While 42 unmarried mothers were admitted to maternity or mother and baby homes the total number of illegitimate births in the county in 1966 was 215.

It is widely accepted medically that the young unmarried mother should be regarded as a high risk case for confinement. The ideal place therefore for this to take place is hospital. I feel that this consideration should weigh heavily in planning the future of mother and baby homes. The case is very strong in my view for these homes confining themselves to the care of the mother and baby, excluding the actual confinement of the mother.

Mrs. M. E. Ellis, Welfare Worker with the North Cumberland and Carlisle City Social and Moral Welfare Association, has kindly provided the following comments on her work during the year, for which I am indebted:—

“A factor I find very disturbing is the number of girls who, rather than go into a Home and care for their child for the first few weeks of its life, are now asking for foster-mothers to look after baby until an adoption can be arranged. Personally, I doubt very much whether this procedure mitigates any of the pain of parting with the child and may engender many regrets later on. Even so, the request for foster-mothers appears to be one of the

trends which will increase rather than decrease, and a survey of the long-term effects on the mother could be very interesting. On the other hand, many of the girls who respond to casework are showing a much more responsible attitude to their child.

“One of the aspects of the work which is always at the back of my mind, is the desire to see much more casework done on the putative father.

“In many cases these boys are as worried and frightened and out-of-their-depth as the girls, but they are elusive creatures and it needs a male case-worker if an adequate attempt to help them is to be made”.

Distribution of Welfare Foods

Area Medical Officers are responsible for the distribution of welfare foods in their areas although the actual distribution is undertaken in the main by members of the W.R.V.S. on an agency basis.

Throughout the county there are 96 distribution points which, in addition to members of the W.R.V.S. who distribute the foods from their homes, includes shops and County Council clinics. To meet the problems of isolated cottages and hamlets in the Pennine and Border hills, arrangements have been made with travelling shops for them to undertake the distribution.

The distribution points get their supplies at intervals of about one month and in the northern area of the county the W.R.V.S. also undertake the delivery of the foods to the distribution points. They use a W.R.V.S. van and in 1966 this involved them in journeys amounting to 6,000 miles.

Considering the difficulties of transport and the scattered population to be served the scheme works remarkably well and, because of the invaluable voluntary component, at the remarkably low cost of £1,000 a year. This covers all distribution costs and stock losses.

The decline in the demand for National Dried Milk continues after seeming to have been halted in 1965, although this may be due in part to the declining birth rate. Over the past ten years the demand for vitamin tablets and cod liver oil has decreased even more sharply but orange juice issues are climbing steadily but slowly from a low point reached in 1962.

The following table indicates the issues of all welfare foods over the last ten years:—

Year	National Dried Milk (Tins)	Cod Liver Oil (Bottles)	Vitamin Tablets (Packets)	Orange Juice (Bottles)
1957	128,219	22,157	6,920	137,336
1958	115,685	15,198	6,338	89,366
1959	105,984	15,350	7,076	93,684
1960	92,676	14,961	7,475	90,343
1961	78,155	9,067	5,017	50,653
1962	79,446	4,712	2,669	31,964
1963	78,858	5,162	2,630	34,943
1964	74,886	4,909	2,236	36,389
1965	78,047	4,636	1,881	39,053
1966	74,902	4,326	1,771	41,636

Dental Service

The Chief Dental Officer, Mr. R. B. Neal, makes the following comments on the Dental Service for 1966:—

“Over the past year there has been very little change regarding the volume of Maternity and Child Welfare work done in the clinics, but one cannot expect to see much alteration, because it is more rational for maternity patients to receive their treatment from the general dental practitioner who usually attends to their needs. It would be quite the wrong principle to attempt to persuade patients to leave their own practitioner for the short period during which they are eligible for clinic treatment. Our colleagues in practice are most co-operative and there is some degree of interchange, which has proved beneficial to both sides, and one can only hope for an extension of this most admirable practice.

“Health education is a subject which has been occupying more time during the past year, and it is with the greatest regret that this vitally important matter will, of necessity, have to be curtailed until more staff can be recruited. Dental officers are very difficult to obtain and unless good working conditions and up-to-date surgery suites are provided, one cannot expect to be able to retain even such staff as one has. Cumberland has a very good name for being progressive and enjoys a reputation for forward thinking, research and advanced clinical methods, but the obsolete equipment must be dispensed with in the near future. Much of it is such that the operator is in a bad operating position, which means that he is prone to the dentist's occupational hazards—varicose veins, cardiac disease or lumbar or cervical spine syndrome.

“There is much opportunity within the clinic service to try out new methods and to undertake original research. One operator has definitely found that modern children react most favourably to pop music—other types have been tried without success. It would appear, therefore, that transistor radios in clinics could be of immense value in helping to relax children and put them at their ease.

"A practical approach to educating parents and children is being worked out through the good offices of the Superintendent Nursing Officer, whereby a pilot scheme will be started and school nurses and health visitors will attend dental inspections in schools. They will then be able to follow progress right through and will be able to try and persuade parents and children that regular dental treatment is necessary and give instruction regarding oral hygiene. Due to the fact that these nurses have access to a patient's home, much good could result from such a scheme."

Fluoridation of Water Supplies

The fluoridation of water supplies is an exercise in preventive health. It is not an alternative to other methods of preventing dental decay but is complementary to them. The teaching of good dental hygiene remains of the highest importance and will continue to receive increasing attention. Education by the health visitors and school nurses in the schools and by the dentists themselves in the clinics is actively encouraging children to take a greater interest in their dental health. When tooth brushes were put on sale in clinics it was surprising how many were sold straight away.

It is as long ago as 1963 that the County Council approved in principle the fluoridation of public water supplies in the county where they are deficient in fluoride naturally. There have been discussions with all the water undertakers and so far three out of six have agreed to adjust the fluoride level in their supplies.

It is in the West Cumberland Water Board's area that plans are furthest advanced. There the necessary equipment is to be installed in new treatment works being constructed at Crummock Water and it is expected to be in operation early in 1968. The water supply to a population of about 60,000 will then have the fluoride adjusted to the optimum to prevent dental caries. The Board's supplies drawn from the Quarry Hill and Hause Gill supplies are to have the fluoride adjusted as opportunity permits, the intention being to co-ordinate the installation of equipment with improvement work to be carried out by the Board. Firm dates for this work have still to be settled.

The South Cumberland Water Board has agreed to the adjustment of fluoride in its supplies from the Ennerdale Water and Baystone Bank sources and, again, this will be co-ordinated with their work which is to be carried out. As a preparatory measure the water is being analysed at monthly intervals so that we may be fully aware of the fluoride content of it and whether it varies with climatic conditions. Similar background work has, of course, been undertaken in connection with the West Cumberland Water Board's supplies.

The measure of agreement which has been reached with these two Water Boards covering the five sources of supply mentioned will eventually lead to the adjustment of the fluoride content in the domestic water for a population of about 130,000 which is more than half the population of the county.

It has also been agreed with the Newcastle and Gateshead Water Company that the water which they supply to a very small area of the county on the Northumberland border will be adjusted to the optimum fluoride level of one part per million.

Negotiations with the Carlisle, Keswick and Eden Water Boards have not been so successful but the foundations have been laid and it could well be that, in the not too distant future, the population in those areas will be asking for the benefits which the other half of the county will have. So that we may be in a position to have comparative information later a survey is to be mounted into the dental condition of children in those areas where the adjustment of the fluoride content of the domestic water has been agreed in principle. It should be interesting to look at these figures alongside those which will be found in years to come.

Child Welfare Centres

Child welfare centres are right in the middle of the developing picture of increased general practitioner participation in preventive health work with the full support of local authority attached staff. The developments in general practice during the year have made it much more likely that general practitioner participation in child welfare work will increase substantially. The movement is gaining momentum daily for the general practitioner to become involved in every aspect of the care of the patients in his practice, and many of the barriers to one general practitioner seeing the patients of another in a child welfare clinic have been broken down. This apart, however, the organisation of well baby clinics on a purely practice basis is more likely to be the foundation of the new development of this service.

These considerations are inseparable from those concerned with premises. It has been clearly indicated by the Ministry of Health in the course of the past year that local authorities will be discouraged from providing and building child welfare clinics unless there is no possibility whatever of these being conceived rather as health centres, and jointly used by general practitioners and local authority staff. I suggested in my report last year that clinic premises might well be increasingly used for day centre activities for the handicapped and elderly. This concept is once again very much in the melting pot in view of health centre type development; and also all of the possibilities associated with the future of local authority welfare services in relation to health services. Should the Seebohm Committee advise the separation of health and welfare services, this could involve a completely divergent development of premises for the handicapped and elderly day activities. All of this but underline the rapidity of development of thought and planning of health and welfare services at this present time.

Against the above background, it is with considerable satisfaction that I can report that one of the newest clinics in the county is about to undergo alterations and conversions for use as a group practice premises. This is at Seascale and by the end of 1966 discussions were well advanced with the newly formed

group practice in that area. I am convinced that this development will demonstrate clearly the wisdom of the health centre type of concept, and may well provide an early opportunity for establishing child welfare and also school health service functions, within the group practice. I hope to be able to report not only the completion of this project, but something of its early working by the time I write my annual report for 1967.

Plans are well advanced for the early building of a new clinic at Longtown on an adjacent site to the new old people's home there, and although there are no plans for health centre type of use of this building at present the situation as we are now observing can change with amazing rapidity.

Some general practitioners have for some time of course conducted child welfare clinics in their own surgeries for their own practice. Where this occurs the health visitor attached to the practice is of course available to assist the general practitioner at his clinics and in fact 328 sessions and 4,607 attendances were involved in this way in 1966. This shows an increase of 10 sessions and 120 attendances over the previous year.

Child welfare centres have been the basis so far of the follow-up of children notified as at risk on account of ante-natal or post-natal factors. It is very clear that this situation which has never been completely satisfactory would be rationalised considerably by family doctors undertaking child welfare work on a practice basis.

The wonderful help of voluntary workers in child welfare clinics is again gladly acknowledged. Outstanding in this is the Women's Royal Voluntary Service.

There were 33 centres in which the County Council provided child welfare facilities in operation at the end of December, 1966. During the course of the year, two centres, the Central Ammunition Depot, Longtown, and the clinic at Jacktrees Road, Cleator Moor, (adapted premises) were closed.

The new purpose built clinic, Cleator Moor, became operative during the year and three further premises were brought into use for child welfare purposes at Silloth, Lorton and Broughton, the latter two being nurses' houses and the former the R.A.F. Amenities Hut.

Of the 33 centres from which child welfare services were provided, twelve are purpose built, seven adapted premises and 14 occupied on a sessional user basis.

Some decline in the total number of attendances has been experienced during the year, 33,521 as against 36,852 in 1965.

This decline, despite an increase of 106 child welfare sessions, is also reflected in the average number of attendances at each session from 28 in 1965 to 23 in 1966.

I have no doubt that this situation is to quite a large extent directly associated with the highly developed attachment schemes of health visitors to family doctors. The health visitors involved in the Park Lane Clinic, Workington, one of the largest in attendance in the county have commented as follows:—

“Since secondment, attendances at the child welfare centre in Park Lane Clinic have dropped 50% approximately.

“Mothers are seeing their own health visitor and family doctor together, also health education is being applied individually”

Referring to one of the smaller clinics on the outskirts of Workington the health visitors report:—

“Seaton child welfare clinic is held twice monthly in the Miners' Welfare Hall, and, with the expanding population, the numbers are increasing. This is now a well established social centre, with a well integrated group of mothers attending and is also a toddlers play centre. There is only one large room with a recess where the health visitor talks to each mother individually and where the medical officer also sees the children. No food is sold at this clinic.”

It is significant that this is one of the areas for which the current building programme provides a new clinic in the near future, and discussion is going on at present with the general practitioner in the area as to the possibility of this developing rather as a small health centre type of project.

The following account of the child welfare clinic work at the new clinic at Cleator Moor is given by Miss Sheppard and Miss Walsh, health visitors, and as it to be expected they commend appreciatively on the modern premises. This is probably the last situation in the county where such a building will be erected without planned accommodation for general practitioner surgery purposes. Indeed this clinic is being looked at carefully at the moment to see whether it is possible to offer surgery facilities there to certain general practitioners who are interested in such a scheme. The health visitors write:—

“Health education—more space is available for demonstrations for both mothers and school children; this, combined with the daylight screen provides improved teaching facilities and this also applies to the ante-natal care, including psycho-prophylaxis.

“Child welfare—the clinic is very pleasant for the purposes of child welfare, and it does, we think, provide the right atmosphere of companionship and privacy when necessary for mothers and young children—the separate room for the health visitors enables them to consult privately with mothers, e.g. family difficulties and problems of care and management.

“Attendances are in range of 40-50 weekly. Cards are now filed separately, according to general practitioner.

“Voluntary help is very good, and consistent—as well as adult helpers this includes children from two secondary modern schools in area, this is to give the children experience in voluntary service, and to tie up with the teaching undertaken by the health visitors within the schools.

“Probation service—at present the probation officer uses the premises fortnightly 4—7 p.m. as their aim is a preventive social service; improved facilities would seem to be in the interest of these young people’s welfare”.

Attendances at Child Welfare Clinics 1957-1966

Year			No. of children attending during the year and who were aged			Total No. of children who attended during the year	Total attendances during the year
	No. of centres provided at end of year	No. of child welfare sessions held per month at centre	Under 1 year	1 - 2 years	2 - 5 years		
1957	...	18	69	1310	1051	1056	3417
1958	...	19	88	1326	1192	1225	3743
1959	...	22	92	1596	1455	1389	4440
1960	...	22	95	1548	1408	1368	4324
1961	...	23	95	1603	1667	1704	4974
1962	...	27	96	1894	1625	2080	5599
1963	...	29	98	1901	1892	2007	5800
1964	...	30	106	2231	1865	2145	6241
1965	...	31	110	2322	2385	2285	6992
1966	...	33	119	2193	2185	2213	6591

CHILD WELFARE CENTRES, 1966

The following table gives particulars of the sessions and attendance at Child Welfare Centres throughout the County:—

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Northern Area					
Alston	Cottage Hospital, Alston	Wednesday	49	355	8
Anthorn	W.V.S. Welfare Office, Anthorn	2nd and 4th Thursday	24	327	13
Aspatria	North Road, Aspatria.	Wednesday	52	866	16
Brampton	Union Lane, Brampton	Friday	52	1643	31
Dalston	Village Hall, Dalston	Monday	47	1055	22
Houghton	Village Hall, Houghton	2nd and 4th Wednesday	24	462	19
Hunsonby	The Institute, Hunsonby	1st and 3rd Thursday	23	447	19
Longtown	T.A. Centre, Longtown	Tuesday	49	1111	22
Longtown C.A.D.		Alternate Monday	6	29	5
Nenthead	Doctor's Surgery	1st Tuesday	9	61	6
Penrith	Brunswick Square, Penrith	Tuesday	48	1458	30
Skinburness	R.A.F. Hut, Skinburness	1st Friday	8	81	10
Scotby	Village Hall, Scotby	1st and 3rd Thursday	24	265	11
Thursby	Church Hall, Thursby	1st and 3rd Tuesday	24	223	9
Wetheral	Village Hall, Wetheral	2nd and 4th Thursday	24	287	12
Wigton	Birdcage Walk, Wigton	Monday	48	1162	24
			511	9832	19

Western Area

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Broughton	Nurse's House	1st and 3rd Wednesday	2	15	7
Cockermouth	Harford House, Cockermouth	Monday	49	1361	27
Crosby, Maryport	Nurse's House, Parkside, Crosby	2nd and 4th Wednesday	21	17	1
Dearham	Nurse's Hse, Central Rd., Dearham	Wednesday	22	175	8
Keswick	13-15 Bank Street, Keswick	Thursday	51	787	15
Lorton	Nurse's House	1st and 3rd Tuesday	20	27	1
Maryport	24 Selby Terrace, Maryport	Tuesday	49	1336	27
Seaton	Miners' Welfare Hall, Seaton	2nd and 4th Thursday	24	677	28

WORKINGTON—

Park Lane	Park Lane, Workington	Wednesday and Thursday	153	3253	21
Salterbeck	Holden Rd., Salterbeck, Workington	Friday	51	1078	21
			442	8726	20

Centre	Address	Day	No. of Sessions	Total Att.	Average Att.
Cleator Moor	Ennerdale Road, Cleator Moor	Thursday	51	2352	46
Egremont	St. Bridget's Lane, Egremont	Thursday	96	1714	17
Frizington	Council Chambers, Frizington	Monday	47	1133	24
Millom	18 St. George's Road, Millom	Tuesday	59	1972	49
Seascale	Gosforth Road, Seascale	Thursday	52	1964	37
Thornhill	Community Centre, Thornhill	1st and 3rd Wednesday	24	503	20
Flatt Walks	Flatt Walks, Whitehaven	Tuesday	49	2041	41
Mirehouse	Dent Rd, Mirehouse, Whitehaven	Monday	47	1856	39
Woodhouse	Woodhouse, Whitehaven	Wednesday	52	1428	27
			477	14963	31
GRAND TOTALS			1,430	33521	23

Family Planning

The subject of family planning has been very much in the public mind in the past year. No doubt this has been contributed to by the active interest which the Family Planning Association have always taken in cervical cytology, itself developing rapidly. The County Council has never directly provided family planning facilities in Cumberland but have supported the Family Planning Association in various ways in their activities, in 5 centres in the county. Millom was added during 1966 to the other 4, viz. Penrith, Workington, Whitehaven, and Alston, where Family Planning clinics have been held by the Association in County Council Premises. There is similarly a clinic run in Carlisle city.

The Ministry of Health issued a circular during the year to local authorities encouraging them to play a more active part in family planning services for those women for whom pregnancy might be in some way a health hazard. The main change which this seemed likely to bring about was some direct financial assistance to the Family Planning Association—something which had never previously been undertaken. Financial stringencies have however deferred this kind of help at the present.

From the figures provided by Mr. J. Pitchford, the Organising Secretary of the Lakeland Branch of the Family Planning Association, it is clear that the steady demand for advice at the clinics continues. The total number of clinic sessions held in 1966 (including Carlisle) was 137, a few more than in the previous year. As would be expected at the present time, there was a doubling of the number advised about oral contraception. The number of visits to the clinics for supplies also increased, although the total number of patients seeking advice showed little change from the previous year. There was also some increase in the proportion of attendances by women who had not so far had any family. Mr. Pitchford himself makes the following interesting comment on the service in 1966:—

“On the whole, progress has been satisfactory. 1966 was a year of considerable re-organisation and consolidation and we now feel that we are geared to cater for an increased number of patients. This we hope to do by advertising. We are particularly

keen to help more patients from the lower socio-economic group and we hope that the various welfare and medical agencies will help us in this work. In view of recent legislation and the fact that general practitioners are now offering family planning advice, I would not presume, at this stage, to anticipate how our services will develop in the future. However, we shall continue to provide and expand our existing services for as long as may be necessary.

“I am pleased to be able to report that the new clinic at Millom has attracted a very satisfactory number of new patients from both Millom and out-lying areas”.

No doubt there will be a gradual, if slow, expansion of this service in future with concentration upon mothers who would not normally take an initiative in seeking such help, although they wish and need it in difficult family circumstances.

Nurseries and Child Minders

The provisions of the Nurseries and Child Minders Regulations Act 1948 require that every local health authority shall keep registers (a) of premises in their area other than premises wholly or mainly used as private dwellings where children are received to be looked after for the day or a substantial part thereof or for any period not exceeding six days; (b) of persons in their area who, for reward, receive into their homes children under the age of five to be looked after as aforesaid.

At the end of the year, there were 16 nurseries registered for the care of 356 children and 4 child minders registered for the care of 75 children. The table below shows the localities and numbers of places provided.

Northern Area	Western Area	Southern Area
Dalston — 20	Cockermouth — 50	Whitehaven — 10
Brampton — 15	Crosby, Maryport — 15	Millom — 20
Longtown — 16	Portinscale — 20	St. Bees — 10
Longtown — 20	Salterbeck — 15	Egremont — 30
Brampton — 30	Seaton — 20	Egremont — 30
Penrith — 35		
Houghton — 15	Workington — 35	Seascale — 10
Scotby — 15		

There is a considerable 'turnover' of nurseries and child minders. Very often a mother begins a group either in her own home or in hired premises to provide essentially for her own children until they reach school age, and at the same time caters for other children in the group. When her own children reach school age her basic interest is often gone and the group disbands. It is equally obvious however that there is a steady development of play groups on a more organised basis, often affiliated to the National Play Groups Association. This is probably a good development in that information on standards and activities is widely shared and adequate provision in various respects in the groups more readily accepted.

Each of the registered child minders or nursery organisers is provided by the authority with the booklets—"Play with a Purpose" and "Not Yet Five", recommended by the Ministry of Health as suitable guides about activities. These provide some basic initial guidance for the organisers who are then visited regularly and advised by the area medical officers and the health visiting staff.

Mr. Bessey, Director of Education, has been in touch with me during the year about possible help which teaching staff might give, and depending on the rate and direction of development of nursery work, I may well have occasion in the future to make use of such advice. The authority does not itself run any nurseries, and although two industrial concerns enquired about establishing nurseries (one in adapted premises and one in a purpose built unit) neither of these projects have so far been pursued to completion.

Marriage Guidance Councils

An annual grant is made by the County Council to the two Marriage Guidance Councils which operate within the county. Accommodation is made available free of charge, at the Park Lane Clinic, Workington, by the County Council, to the Carlisle, Cumberland and Eden Valley Marriage Guidance Council. The former and the Catholic Marriage Advisory Council have a centre in Carlisle.

The principles of the Marriage Guidance Councils are primarily concerned with successful marriage, the foundation of a happy family life which is vital to the well-being of society. The following table indicates the number of new cases dealt with annually, since their establishment:—

Year	Carlisle, Cumberland & Eden Valley Council		Catholic Advisory Council	Total
	Carlisle	Workington	Carlisle	
1961	49*	—	—	49
1962	57	—	—	57
1963	55	19*	18	92
1964	15	36	15	66
1965	39	39	3	81
1966	42	17	2	61

* Part year only.

The Secretary of the Carlisle, Cumberland and Eden Valley Marriage Guidance Council has kindly supplied the following report on the work of the Council during 1966:—

“The work of the Carlisle, Cumberland and Eden Valley Marriage Guidance Council has remained steady during 1966. Seventeen cases were seen at the County Council Clinic, Park Lane, Workington, and 42 cases of which 16 couples were resident in the county, and 26 in the City of Carlisle, at the Marriage Guidance Council’s headquarters in Carlisle.

“A total of 133 interviews were given (43 in Workington and 90 in Carlisle); of these families the Council tried to help, there were 87 children under the age of 16 years. We have been seriously handicapped in the past year by the lack of trained counsellors, two moved to the south of England and for the latter part of the year we were left with only one in Workington and one in Carlisle.”

Health Education

Every section of the health department's work is now dominated by the contemporary movement towards unification of medical care outside of hospital on a group practice basis. If it is accepted, as is so often stated, that health education has always been one of the main responsibilities of local health authorities, then the future of this work must also be reviewed in the light of present trends. I believe that the major advance already achieved in the county of close attachment of nursing staff to general practitioners has affected the quality of health education carried out by the nurses. Health education is after all mainly about attitudes and I believe that nothing will do more to foster a proper attitude to health than a confidence that both preventive and therapeutic work for the individual are securely in the hands of a close knit and well integrated team.

This applies in my view with equal force to the more traditional forms of health education which health visitors have diligently pursued over many years; and to the emergent opportunities associated with preventive health screening procedures. With regard to the former, the health visitor can pursue her educative work with mothers, children, and the elderly in particular, at the individual level in the fuller confidence that the family doctor is both aware of what she is doing and in accord with her general intentions. This includes such basic matters as advice on infant care including feeding, and diets for elderly people.

In the newer field of health screening procedures, the handling of these by the same integrated team of workers cannot fail to command community respect and attention more quickly and readily. As indicated in the section of this report which deals with cervical cytology screening, the real future for this work is on a group practice basis, where much more rational arrangements can be made for the attraction of mothers (including those in the highest risk groups) to attend for cervical smears.

This naturally leads on to the other major aspect of present developments, viz. joint use of premises by the local authority staff and general practitioners. Here I visualise the main advant-

age to health education being also in the group situation. While it is true that with efficient appointment systems there will never be large numbers of people in health centre premises at one time to consult the doctor, it nevertheless must become the main focus of community health activities. Therefore in designing group practice or health centres, provision of waiting space as generously as possible is necessary, which can be adapted at appropriate times for group health education work.

It is against this background that Miss Mansbridge, Superintendent Nursing Officer makes the following comments on health education activities in 1966:—

“Health education obviously means something different to each individual and each individual therefore responds to the call of education for health in a way which personally appeals most. While all health visitors are educated in the knowledge that ‘a health visitor’s function is mainly that of a health educator’ there are few who accept this as a whole-time job; the majority combine health education with their general work as a health visitor and, consequently, specialise in educating one part of the community. One health visitor will concentrate on the young mother and give extra time to running a Mothers’ or Parents’ Club in the evening; another is interested in teaching the school child and yet another in the elderly and helping them to keep as well as possible during their advancing years. Each group has an importance of its own. Many health visitors feel their best health education is done individually in the home, and there is much to commend this, as not everyone can be reached through group discussion or lectures. Some mothers probably remember more from an individual talk in the quiet of home than from a group meeting when there may be distractions at the time of worry regarding a home situation.”

During the year the Mothers’ Clubs at Egremont, Workington and Brampton have each carried out an interesting programme and Miss Surtees, health visitor in Workington, writes:—

“During the past year some of the mothers requested two meetings a month, so that there would be time to include more health education in the programme.

"The following subjects were included, cancer education the 'kiss of life', first aid in the home, dental care of your child's teeth. Films were also shown followed by discussion and the two which provoked most interest were 'The Bridge' which shows the adverse effect tensions in the family relationships can have upon a child, and 'Fifty-Two Small Bones' was followed by a talk and discussion on care of the feet and wearing of correct shoes with examples of the incorrect type of shoe on view. Talks on infant nutrition and suitable cookery demonstrations have proved very popular, as have demonstrations on the lighter side, including Judo, jewellery making and flower arrangement. During the winter months the club members organised a sale of work which was most efficient and successful and the proceeds were given to cancer research.

"I find the mothers can relax more in the evenings and enjoy the health education programme better than those held during the clinic sessions. They enjoy the social meeting together over light refreshments".

The Egremont Mothers' Club is run on much the same lines and Miss Crosby writes:—

"In addition to the varied educational programme we have had some very pleasant outings and have visited the Cheshire Home at Ambleside, the Workshops for the Blind, Irton Hall Spastics School, and the Outward Bound School at Eskdale. The yearly programme is prepared well in advance and the attendance at each meeting is well maintained in spite of a changing population. I feel this is a well worth while project, and much appreciated by the mothers."

As health education should embrace the whole family, it is important a start should be made while the child is at school. It is with the school child that some of the health visitors have done some most valuable work and the following contribution by Miss Sheppard, who works in West Cumberland, explains the method she has found most useful:—

Miss Sheppard writes—

“We have continued with weekly talks in the two secondary modern schools and are trying to bring into being a series of health education talks which will allow for discussion of health hazards and their effects on individuals and communities; we are having some difficulty with this as it is such an involved subject. Our aim is to teach health in such a way as to encourage the child to understand and act sensibly within a given environment, to her own best advantage, thus increasing her ability for co-operation, understanding and service to others.

“We give some explanation as to the reasons why people feel and act as they do, and have found the most effective way to do this is by a diagram of the structure of the human brain explaining (what we know!) of the way in which basic needs are influenced by the development of the cortex, when this is understood, it is less difficult to explain to the children both usual behaviour and also such things as mental illness, alcoholism, venereal disease, drug addiction, etc.

“Usually we teach by using the blackboard and asking questions—such as ‘Who is important to a baby and why?’, illustrating by a graph on human relationships or, ‘What effect does an addiction such as alcoholism have on (a) the person (b) the family (c) breakdown in health (d) family break-up?’

“One school has extended its concern for community care by cooking a meal under supervision for the elderly people attending the Cleator Moor luncheon club”.

There is often in practice, only a very fine line of demarcation between the promotion or maintenance of good health and the prevention of disability and undue social dependancy and nowhere is this more marked than in the elderly. Physical handicaps which limit movement and cause confinement to the home, or deafness in any degree which causes misinterpretation or misunderstanding, will in either case prove a disability leading to social dependancy. I am sure that individual health education is the main answer.

The other approach to this group is by means of talks given and films shown at the regular 'Over 60' club meetings which prove very popular.

Miss Lockhart, health visitor, in Alston, states:—

"I now have a complete register of the residents of pensionable age and I do a great deal of visiting among this group. I am able to talk to them about diet, safety precautions in the home and other suitable subjects. It also gives me the opportunity to advise on the various services which are available to them and about which they may not have adequate information".

Talks have been given by the administrative staff to members of several 'Over 60' clubs and Miss J. Reid, Area Nursing Officer, has taken part on more than one occasion in the programme "Preparation for Retirement" arranged by the Whitehaven College of Further Education, her subject being diet, activities after retirement and the availability of the home help service to assist when necessary.

The expansion of the health education programme either through public meetings, group discussions, or individual talks includes the following subjects: accident prevention and first aid, health of the child and adolescent, home nursing and the care of the elderly, diets for the elderly and many general health topics, including the prevention of disease.

The following table shows the number of talks given and attendances in 1966:—

	Talks	Attendances
Talks at clinics	215	2,518
Talks at schools	191	5,413
Mothercraft and relaxation classes ...	337	2,054
Talks at other meetings, Mothers' Clubs, W.I. meetings	142	1,950
	885	11,935

Health education in the ante-natal period includes a constantly developing programme both by the individual and group methods. The health visitors and midwives co-operate in this and work through a comprehensive syllabus which meets all needs. With the secondment of staff to general practitioners there is more opportunity than formerly to meet the patients at the surgery. Many of these patients are booked for hospital confinement, but after the first visit do not return there till the 32nd week. It is during this period that the midwife and health visitor see the mothers and have the opportunity to talk to them on such subjects as the need for ante-natal care, diet, hygiene, breast feeding, labour and analgesic. Film strips and flannelgraphs are used to demonstrate the birth of the baby. Relaxation exercises are demonstrated and classes held wherever possible. The mothers undoubtedly appreciate the link of the midwife and health visitor with the family doctor, which consolidates the care they receive.

Health visitors have also taken an active part in the programme of health projects for the Duke of Edinburgh's award scheme and have given courses of lectures to Red Cross groups, both junior and adult.

Health education knows no limits and is as wide as the community, giving information on health matters for its protection, help and care. An essential in this programme is the co-operation and acceptance by the staff who must be suitably trained to further this work.

VACCINATION AND IMMUNISATION

Section 26 of the National Health Service Act, 1946

“Every local health authority shall make arrangements with medical practitioners for the vaccination of persons in the area of the authority against smallpox and the immunisation of such persons against diphtheria”.



VACCINATION AND IMMUNISATION

The implementation of the County Council's scheme for vaccination and immunisation against some of the major infectious diseases continues to be an aspect of the work of the department of cardinal importance in community health. It is only too easy to forget that the maintenance of high standards in this field is the only guarantee against the recurrence of a situation of great hazard to the youthful population of the county in particular, in terms especially of diphtheria and poliomyelitis.

Up to the present the protection of children against notably smallpox, diphtheria, whooping cough, tetanus and poliomyelitis, has been a dual responsibility of local health authorities and family doctors. In 1966 60% of all injections and immunisations were carried out by the Council's medical staff, the remainder by general practitioners. There is no statutory obligation on the latter to provide such a service, though a substantial proportion of immunising protection has always been given by general practitioners, especially to pre-school children. Recent, and indeed current, important changes in general practice, and in the relationship between local health authority and general practice has been bringing about important changes also in the arrangements for giving protection against these infectious diseases.

The first major development was the attachment of local authority health visitors to general practice. This immediately provided a better means of co-ordination of protection given at clinics and in surgeries. A great deal of careful and painstaking work has been carried out by the health visitors over the years ensuring as high a level of protection as possible and their position in this work has been greatly strengthened by their attachment to general practitioners. As a natural consequence of the attachment of nursing staff to group practices, it was apparent that there were many tasks which nurses could suitably carry out on behalf of doctors, both in the home and in the surgery, which would integrate more completely the work of both. One of these tasks it is clear is the carrying out of certain immunisation procedures, and at the time of writing this report an arrangement is being worked out with family doctors whereby professional responsibility will

be appropriately shared at the medical and nursing levels, and nurses will be able to give family doctors a great deal more help in this field than hitherto.

At exactly the same time, a completely revised scheme of recording and paying for immunisation work done by general practitioners is being introduced by the Ministry of Health, and I will comment in greater detail on this in my next annual report. It does seem likely however that this new procedure will lead to a higher proportion of immunisation work being carried out by family doctors with the assistance of attached nursing staff.

Yet another development which will tend to lead in the same direction, is the likely participation in the near future of more family doctors in child welfare clinic and school health service work. It seems very clear that wherever possible in the near future group practices will become involved in taking over this work for the young patients of the practice. Apart from the more specialised task of giving B.C.G. vaccination against tuberculosis to 12 year old school children, immunisation procedures generally will pass still further into the hands of the family doctor.

It is the greater pity in view of the above developments that it has not been possible to plan in detail for the comprehensive use of the County Council's computer in dealing with vaccination and immunisation call-up arrangements. It has been clearly demonstrated in a few parts of the country by now that this can be done with great efficiency and satisfaction to all concerned and, what is most important, it can effect significant improvement in the immunisation rates. The basis of such a scheme is the entirely automatic call-up of children for each dose of antigen when it is due. The expense of additional computer equipment to do this has caused the scheme to be deferred, but I look forward to the time when this ultimate refinement of call-up for immunisation procedures will be able to serve all of the doctors in the county doing this work.

I show below the statistics for 1966 on the main vaccinations and immunisations given with a brief comment on each.

(a) **Diphtheria Immunisation.**

The numbers of children immunised during the year were as follows:—

Primary courses—pre-school children	...	...	2,938
Primary courses—school children	...	...	916
Reinforcing injections—pre-school children	...	...	1,617
Reinforcing injections—school children	...	...	5,472
TOTAL			10,943

The figures for diphtheria protection show again a slight improvement on the previous year, but the only simple guide to completely satisfactory protection of the child population would be the giving of primary courses to pre-school children at the rate of approximately 4,000 a year, which would correspond to the birth rate, and the giving of reinforcing injections to school children at the rate of some 7,500 per year, representing almost twice the school population. This is because school children should really receive two reinforcing injections at the ages of approximately 5 and 10 years. It should be recognised that the true figure for the year is almost certainly a little higher than that shown above since it is known that all doctors' records of immunisations given are not comprehensively notified to the local authority. The system about to be introduced early in 1967 for primary notification by the general practitioner to the executive council gives promise of more comprehensive information in the future.

(b) **Whooping Cough Immunisation**

3,068 children completed a primary course during 1966, and 1,864 received reinforcing injections. This is of course entirely confined to pre-school life, the reinforcement being given as

recommended at about eighteen months. It is clear that this latter procedure is not being taken up as comprehensively as it should be, although the initial protection in early infancy against whooping cough is the issue of major importance here. Again only a figure approximating to the birth rate would indicate complete protection of the infant population, and we continue to fall short of this. Perhaps fewer young parents today have any experience of the extreme distress caused to a child by whooping cough. Fortunately health education of parents in this matter is combined with the case for diphtheria and tetanus protection since all three are given as triple antigen.

It is not recommended that any further reinforcement of whooping cough immunisation is of any value after school entry.

(c) **Tetanus Immunisation**

The number of children receiving protection during the year was 10,759 and grouped as follows:—

Primary courses—pre-school children	...	...	2,929
Primary courses—school children	...	...	1,096
Reinforcing injections—pre-school children	...	...	1,616
Reinforcing injections—school children	...	...	5,118

The remarks made above with regard to diphtheria protection apply equally to tetanus. All children protected against tetanus are notified to the major accident hospitals in the county, 10,263 notifications being sent in 1966. Similarly this information has been passed on to family doctors. It is known that in some cases this has proved useful in hospital casualty departments and has enabled children to receive a reinforcing injection—a much more pleasant and less hazardous experience—rather than be given anti-tetanus serum.

A scheme was discussed with Local Medical Committee whereby adults given an initial protection in hospital following an accident, might be followed up with the help of health visitors to ensure that they attend their family doctor for completion of tetanus protection, but the Local Medical Committee felt there were difficulties in the way of this and the scheme has not gone forward.

d) Smallpox Vaccination

The following table shows the numbers of children given smallpox vaccination in the past six years. I am glad the figure is increased, but once again it will be seen when related to the approximate 4,000 births annually in the county, less than half of our children are being protected against smallpox. Therefore approximately one-half of the parents in Cumberland can afford to rest content about their children's safety in terms of the scourge of smallpox which is an ever present possibility in the world of increasingly fast international travel. It is true that important measures in recent years are being under taken by the World Health Organisation, and a vast amount of international effort is going into the ultimate eradication of smallpox. This is however undoubtedly quite a long way off, and routine vaccination of children remains a most important bulwark against invasion and spread by this disease.

In the case of smallpox vaccination the largest proportion of the work is done by family doctors, and no doubt this will continue to be so.

Year	Age under one year	Age One year	Age 2—4 years	Total
1966	300	1,160	364	1,824
1965	464	893	210	1,567
1964	594	742	119	1,455
1963	786	208	80	1,074
1962	2,150	322	428	2,900
1961	1,816	154	119	2,089

(e) **Poliomyelitis Vaccination**

The number of children in the different age groups receiving either primary courses or reinforcing doses of oral vaccine during the year are shown below with the corresponding figures for the previous year in brackets:—

Primary courses—pre-school age	...	3,147	(3,405)
Primary course—school age	...	1,597	(1,089)
Reinforcing doses—pre-school age	...	119	(107)
Reinforcing doses—school age	...	3,626	(4,697)
TOTAL		8,489	(9,298)

The more comprehensive protection of children of school age against poliomyelitis continues I am glad to say, following the special effort made in 1965. I do hope that parents will never lose sight of the tremendous importance of keeping their children's protection up in this field as in the others mentioned above.

(f) **Vaccination against Measles**

There has been no development in this field in 1966. It was not generally felt by the doctors in the county that there was a case for wide introduction of measles vaccination, and this is in accordance with the advice of the Ministry of Health Joint Committee on Immunisation and Vaccination. Individual doctors may still elect to use measles vaccine for their patients should they so wish. It seems clear that the wider introduction of measles protection will depend upon the development of a vaccine which will cause less in the way of reaction in the recipients than the material at present available. This could presumably occur at any time since refinements and improvements to such vaccines are constantly being pursued by the pharmaceutical companies concerned.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Section 28 of the National Health Service Act, 1946

“A local health authority may, with the approval of the Minister, and to such extent as the Minister may direct shall, make arrangements for the purpose of the prevention of illness, the care of such persons suffering from illness . . . , or the after-care of such persons, but no such arrangements shall provide for the payment of money to such persons, except in so far as they may provide for the remuneration of such persons engaged in suitable work in accordance with the managements.”



"DOMICILIARY CHIROPODY"

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

I drew attention in my report last year to the way in which newer concepts in preventive health are gradually taking over the foreground in this picture from those conditions which previously dominated the authority's responsibilities under this section of the Act. The latter included the after-care of tuberculosis which is now a relatively small commitment. Still under this section of course come the provision of convalescence for appropriate cases and of equipment on loan to patients at home when this is required for the treatment of a temporary illness. Long term disability is catered for in these terms by the Ministry of Health on the prescription of a hospital consultant. This refers mainly to wheelchairs, walking aids, and suchlike equipment.

Apart from cervical cytology reported on again below, the developing field of health screening procedures has continued to be studied carefully and closely throughout the year. This has not so far resulted in any major project along these lines being commenced in the county, although I will mention briefly below a pilot survey of persons over the age of 70. The main reason for what may be thought of as slow development of health screening or advisory clinics is the growing conviction that these will only be satisfactorily conducted and run on a practice basis where a group of doctors in partnership will provide such a service for their own patients with the fullest support by local authority nursing and other staff. Naturally before this can become really effective, two things must take place—firstly the local authority staff must be really integrated in their work with the general practitioners; and secondly adequate premises as far as possible jointly used by general practitioners and local authority staff, must be available for the work. The first of these requirements is of course well advanced in its development in this county, and the second is now showing signs of advance in various places. This is all intimately related of course to the far reaching changes which are occurring in general practice conditions, organisation, etc., and the marked contemporary resurgence of interest in health centre development. It is therefore, not surprising that the first pilot survey of a group of persons over 70 years of age should have been conducted in 1966 by and with a group practice with

securely integrated local authority staff attached and with well organised and reasonably adequate practice premises.

This pilot survey was in fact conducted in the patients' own homes, and it was found best to employ a part-time nurse specially to conduct this under the general guidance of the doctors and the attached health visitor. As stated this is but a pilot venture, and I am in discussion with many colleagues at present as to how it should best develop. The initial basis of the exercise was the completion of a simple and reasonably short questionnaire on the social and medical conditions of the individuals, which will provide enough information for the family doctor to assess any special hazard to his patient. It has not been mounted as a truly research project, and the extent to which this might be involved is one of the points under consideration at present.

During the course of this pilot survey of 100 patients (and similar 'pilots' are being repeated now with other practices in the county), a haemoglobin estimation was introduced since it seems to be increasingly clear that this is one simple clinical test which may well reveal a wide area of readily treatable pathology in elderly people—as indeed in other groups of the population as well. I hope to be able to report more fully on this over 700 enquiry next year.

CERVICAL CYTOLOGY

The cervical cytology service has continued during 1966 in County Council clinics. Sessions were held at 11 clinics, viz, Carlisle, Brompton, Penrith and Wigton in the Northern Area; Cockermouth, Maryport, Salterbeck, and Workington in the Western Area; and Whitehaven, Cleator Moor and Millom in the Southern Area. There are 14 sessions in all per week devoted to the service, most run on an appointments basis. The taking of smears continues to be done by the nursing staff trained for this purpose. This is in accord with the wish of the consultant obstetricians and gynaecologists.

In the nine months of 1965, during which the authority was running cervical cytology clinics, 1,715 smears were taken, 6 of which proved to be positive. 1966 showed a much better response by women between the ages of 35 and 50, for a total of 4062 smears were taken by local authority staff during that period. 24 were positive, a rate of 6 per thousand.

Early in the year it had been established that the majority of those attending the clinics were from social classes 1, 2 and 3, and that only 6.7% were from social class 5, where the risk was thought to be greatest.

A domiciliary service seemed to offer the best solution to the problem of getting those in the lower socio-economic group to co-operate and, after a small pilot scheme, a domiciliary service was instituted. It is operated in consultation with general practitioners and it is interesting to note that of 155 smears so taken 3 were positive, a rate of 19.4% per thousand.

Evening clinics were instituted for the benefit of women who were working and, in addition, by arrangement with the management, nursing staff visited a factory and took smears from members of staff.

Still considering the mainly administrative side of the service it has proved of value to regularly meet with general practitioners, gynaecologists and pathologists to consider the arrangements for clinics.

An interesting side factor of the cytology service is the number of women found to have some form of cervical infection such as trichomonas, or cervical erosion, who have been referred to their general practitioners for treatment. Forty women benefitted in this way during the year.

Two points under discussion have been the method of letting women know of the results of smears taken in local authority clinics and the use of the standard record card recommended by the Ministry.

Previously the results of smears were notified by the laboratory direct to general practitioners and the women had to visit the doctor's surgery to find out what the position was. As attendances increased this imposed a burden on the surgery arrangements of some general practitioners and, after discussion, it was decided that a simple notification would be sent direct from the laboratory to each woman with a negative smear, a pre-addressed envelope having been sent from the clinic to the laboratory with the smear. Where smears are positive or suggest the need for further investigation, or even treatment for some other condition, the notification is sent to the general practitioner and it is his responsibility to contact the patient and explain the situation. This seems to be working quite satisfactorily.

So far as the standard form is concerned a decision on its use has been deferred, although the general opinion here, as in many other parts of the region, seems to be that it should not be used. I see probably the biggest bonus from its use to be the recall arrangements which without it is going to be a difficult exercise in the future.

Trying to look at the service in the light of experience so far and the current changes taking place in medical practice generally, it is important I believe to recognise the most important way in which this service is likely to develop in the future. Considering the question of numbers attending, it has been noted that the attendances are falling from those recorded in the early days. In the first 21 months of the service, something less than 6,000 women came to the clinics out of a total figure of 25,000 who were

eligible to attend in the main risk age group, viz. 35-50 years of age. The initial level of interest in this service was to be expected to drop away to some extent when the majority of women in the group who are most health conscious had attended. While the present level of attendance therefore seems low, it has to be considered in the light of the fact that a five-year attendance cycle is generally recommended. So long therefore as the attendance rate allows of the 25,000 eligible, plus the annual "increment" coming into that group, being gradually covered, the situation would be reasonably in hand.

The more important consideration in the whole subject however in my view, is the proper location for the future of cervical cytology work, something which in itself will undoubtedly be the vital factor in securing the attendance of a high proportion of women eligible for the service. It is clear to me that this is in fact the development of this work in the general practitioners' practice premises rather than in County Council clinics; with full attachment of local authority staff to general practitioners providing all the necessary assistance in the surgery for cervical cytology. I am sure that the attendance of women will be much more readily secured through the family doctor's direct advice and provision of a service convenient for people attending the surgery often for other causes. This is entirely in keeping with the general movement towards the general practitioner assuming full responsibility for patient care. I feel also that this will be more effective in the end in solving the problem of the lower socio-economic groups which are known to have the high positive rate for cervical smears. The taking of smears in doctors' surgeries, together with a continued if limited domiciliary service, all as part of a general practitioner service, will no doubt make the greatest impact on this group.

Tuberculosis and Diseases of the Chest

Dr. Morton and Dr. Hambridge, Consultant Chest Physicians in East and West Cumberland respectively, have again kindly provided me with copies of their annual reports for inclusion as appendices to this report. It is reassuring to note how the careful and vigilant control and treatment of what tuberculosis now remains, is continuing in the chest clinics.

During 1966 the changed pattern of health visitor support continued in the West Cumberland Hospital Chest Centre, so that fully specialised health visitors in tuberculosis work are no longer employed, but the follow-up work in the home is conducted in the main by the health visitor attached to the general practitioner whose patient is concerned. This change was accepted only with some reservation by the chest physicians in West Cumberland, and I appreciate and indeed share their concern that there should be no deterioration in the standard of health visitor follow-up work in cases of tuberculosis. However I do believe that in the long run the balance of advantage will be shown to lie with the carrying out of this work by the health visitor attached to the family doctor, and discussion has taken place on various methods of ensuring that communications between the health visitors and the chest clinic are maintained satisfactorily.

In Dr. Morton's report, attention is drawn to the importance of the careful follow-up of the immigrant population. Although this is a small problem in this part of the country, it clearly only requires one infectious case of tuberculosis in a person in a key employment situation to provide a real menace to very many people. Apart altogether from the protection of the population generally, which is the primary concern, it is clearly a service of the greatest value to immigrants that a chest X-ray should be insisted upon.

It is no matter of idle routine to record my very sincere thanks to Dr. Morton and Dr. Hambridge for their full co-operation and help throughout the year in all of the aspects of tuberculosis work which remain with this department.

AFTER-CARE OF OTHER ILLNESSES

Section 28 of the National Health Service Act provides that local authorities "may make arrangements for the care of persons suffering from illness or the after-care of such patients" and these include the provision by the local authority of equipment necessary to the nursing of patients in their own homes. This mainly concerns the loaning of equipment for short term use at home and consists mainly of wheelchairs, commodes, walking aids, etc. While the Ministry of Health accept, on hospital recommendation, the responsibility for providing long term equipment, it is often necessary for an initial period to be met by the local authority loan equipment arrangements. The very efficient way in which these are carried out by the British Red Cross Society, acting as the agents of the County Council, deserves the highest praise. They issue equipment from three depots, one of which is situated in each of the three administrative areas, as follows:—

Carlisle: 2 Chatsworth Square	Monday-Friday, 10 a.m.—12 noon
Workington: 59 Station Road	Tuesday and Thursday, 10 a.m.—12 noon
Whitehaven: Whitehaven Hospital	Tuesday and Thursday, 10 a.m.—12 noon

The provision of equipment insofar as the local authority is concerned, is primarily of a short-term nature and the availability of such equipment for re-loan is of prime importance in an endeavour to keep down costs in the purchasing of new appliances.

The demand for this sort of equipment can only increase with the advancing volume of disability in the ageing population. That a very amicable working arrangement exists with the hospitals vis-a-vis temporary as against long term equipment is very gratifying.

Equipment	Items issued during				1962
	1966	1965	1964	1963	
Commodes	141	145	105	98	76
Crutches	31	62	65	34	17
Hospital Beds	12	10	22	9	11
Invalid Chairs—					
Adult type	167	176	134	141	105
Junior type	5	22	8	7	10
Mattresses—					
Rubber	14	15	21	20	31
Inflatable	3	3	8	3	3
Tripod Walking Sticks ...	159	150	130	127	91

Major items of equipment issued during the year and the previous four years are summarised in the above table.

Domiciliary Physiotherapy Care

This report is made at a time of change in that both Miss Morris and Miss Fraser the two County Council orthopaedic physiotherapists have resigned to take up other posts and considerable thought is being given within the department to the future pattern of physiotherapy work in the medical home care team. With the progressive development of group practice and health centres, it seems likely that groups of general practitioners will find a need for some assistance from a physiotherapist both in the health centre and in the home. Meantime efforts are being made to replace Miss Morris and Miss Fraser, both of whom have given excellent service to the county over a number of years. The following report has been contributed by them about their work in 1966.

"The service continued to operate throughout 1966 with two full time orthopaedic physiotherapists covering the county; Miss Morris being based in the Northern Area and Miss Fraser in the Southern Area; the work in the Western Area being divided between them.

"With such large areas to cover, and with orthopaedic after-care clinics for pre-school and school children occupying a large part of the physiotherapists' time, it follows that when either of them is called upon to give domiciliary treatment, it is understood that it is mainly in an advisory capacity, even so a lot of home visiting has been done during the year.

"The physiotherapist in the first instance shows the patient and his relatives home exercises to carry out. She measures and fits the patient with a splint and walking aid where necessary, and thereafter visits at intervals to check on progress. The movements are carried out daily by the patient, with help and encouragement from his relatives and in many cases from the district nurse as well.

"At this point it may be well to emphasise that the service is intended primarily for those who are too ill to attend, or live at too great a distance from a hospital physiotherapy department. Where a patient is fit to travel to hospital by car, he should be encouraged to do so, particularly when home conditions are cramped. The space and facilities available in a hospital department for the rehabilitation of patients are such that in the majority of cases they ensure more adequate treatment and therefore more rapid progress.

"Where a patient is being treated at home following a stroke, the physiotherapists urge that they be informed at the onset, so that they may visit at the earliest opportunity to show the patient's relatives the passive movements necessary to prevent stiff joints and contractures, and to encourage active movements from the beginning. As the best way to re-educate paralysed muscles is to use them frequently for the purpose for which they are intended, the patient should be encouraged to do things for himself as soon as possible. These patients divide into two types—those who

tend to rely on our visits and help and are unwilling to make too great efforts for themselves, and others who, when they once realise they can get back to their old life, even in a limited way, do not want to be visited any more and are anxious to appear as normal as possible.

“The severely handicapped arthritic patient is more difficult to help. They have become resigned to their condition, and apart from providing and inventing gadgets to help them to do the simplest things, such as getting a cup to their lips, combing hair, turning the pages of a book (work for which an occupational therapist would be more useful) visits tend to become mostly social”.

CONVALESCENCE

Dr. J. L. Hunter, Western Area Medical Officer, writes as follows:—

“The arrangements by the authority for convalescent care for adults continued during 1966 but the provision was not so extensive as during the previous year. The scheme provides primarily a stay of a fortnight at a convalescent home for adults who have passed through a trying period either of an acute illness or of an exacerbation of a more chronic condition, and benefits mainly those who perhaps cannot afford to recuperate away from home under completely private arrangements.

“The convalescent home of choice has naturally been the Silloth Convalescent Home which is well established in many respects—in its pleasant situation on the Solway, in climatic conditions that are generally mild and agreeable to most cases, in its accessibility by road at any time of the year, and by reason of its good reputation in care, comfort and consideration. The Home is registered as a Nursing Home under the Nursing Home Act of 1963, is run on a non-profit basis under the guidance of an active committee and is well staffed by matron, nurses and ancillary staff.

“Although nursing staff and skill are present and available in the Home primary selection of cases by the family doctors is directed towards referral of those who require the minimum of medical care. A case must of course be ambulant and capable of deriving benefit from all the amenities provided. The basic concept in the word ‘convalescence’ is getting strong or getting well after illness or operation and a convalescent home should function with the main intention of guiding the case towards getting strong or well as quickly as possible without having worry and strain of having to achieve this in the face of domestic work and family responsibility. This applies increasingly with age and it seems to me that a convalescent home justifies its existence in catering for such circumstances. One finds indeed that the main selection of cases is among the elderly.

"What are the criteria in selection of cases? From a general standpoint the reason for selection is implicit in the word 'convalescence' and in what has been said above. From the clinical point of view it is refreshing to find an almost complete lack of the word 'debility' in the certificates rendered by the family doctors. Conditions of the heart and blood vessels feature largely in recommendations for a period of convalescence—coronary disease, cerebral thrombosis, arterio-sclerosis, mitral stenosis, hypertension. Other conditions to be noted are prolapse with menopausal bleeding, cystitis, recurring bronchitis, pneumonia (alone or concomitant), various fractures involving operation, cataract after operation, and abdominal conditions after operation. In addition a few cases of mental illness have been accepted—depressive state being the main factor in those coming forward. It is also pleasing to note that many family doctors in different districts were concerned in the referrals.

"The provision by the authority has increased since 1961 from 36 total cases in the county to 144 in 1965 and this latter figure might well have been exceeded in 1966 but for the enforced cutting-down of expenses in the second half of the year. In comparison to certain other authorities Cumberland County Council ranks high in this service as is shown in the table which follows:

	Rate per 1,000 population			
Cumberland C.C.	...	...	...	0.5
West Riding, Yorkshire	...	...	...	0.1
Lancashire	...	...	...	0.1
Durham	...	...	...	0.03
Northumberland C.C.	...	...	...	0.1

"Within this authority the rate for the Western Area was 1.2, a figure which is noted in the report of 1965 as arousing interest. It is also interesting to note that in the same area the waiting-list for Part III accommodation is the highest of the three areas and that the number of known handicapped persons is highest also (in the ratio: Northern Area, 4; Western Area, 6; Southern Area, 5). It might appear that although the need for services is likely to be evenly spread over the county there have been favourable factors

obtaining in the Western Area for the need to emerge and be noted. One such factor, particularly in relation to convalescence, may have been the fact that attachment of nursing staff to family doctors started up first in the Western Area giving an advantage to the area in that tripartite association of patient, doctor, and nurse, which seems to me to be the best and most fruitful in bringing forth cases of difficulty and cases requiring support and help.

“Ninety-nine persons were admitted to the Silloth Convalescent Home during 1966, over half coming from the Western Area. From information received benefit in rest, good food, company and happiness resulted particularly in the elderly.

The figures of admissions for the authority to Convalescent Home is given in the following table:—

Convalescent Home			1962	1963	1964	1965	1966
Silloth	...	...	55	51	83	141	97
Other Homes	...	...	6	1	—	3	2
TOTAL	...	...	61	52	83	144	99

The meetings of the Convalescent Home Committee to be attended by myself or my Deputy”.

CHIROPODY SERVICE

The authority's free chiropody service for expectant mothers, the physically handicapped and the elderly has now become an established part of community care and a total of 5,745 patients were receiving treatment at the end of 1966. This is, in fact, fewer than were on the register at the beginning of the year despite the referral of 1,293 new patients during the period. An abnormally high number—1,496—were taken off the register due to re-organisation which will be explained later.

The continuing high proportion of patients who have been certified as in need of domiciliary treatment continues to be one of the main features of the service, although figures recently published indicated that the national average is not much less than the Cumberland figure. Our problem is, however, aggravated by the distances involved. Of the new patients accepted for treatment no fewer than 30% had to be treated at home. Overall, 27% of the patients are now domiciliary, compared with 25% in 1965. This is undoubtedly imposing a serious burden on the service, both in terms of the manpower needed when so much travelling is involved and in the cost. I would emphasise, however, that all these domiciliary patients have been certified as such by general practitioners—nursing staff may refer only for clinic or surgery treatment—although the disproportionate way in which they are spread throughout the county does give rise to some concern. For instance, 26% of the new patients in the Southern Area were referred for domiciliary treatment, against a figure of 30% for the Northern Area and 34% in the Western Area which, being more urban in character, is the most compact of the areas and probably has by far the best public transport arrangements. The same kind of disproportion is apparent in the total numbers of patients as, although the three areas are of almost equal population, the numbers getting chiropody treatment vary from 1,423 in the Southern Area to 1,949 in the Northern Area and 2,373 in the Western Area.

Although the service is available to three priority groups of patients, in practice its benefits are enjoyed almost entirely by the elderly. The expectant mothers and the handicapped form a negligible proportion—less than 1%—of those treated. Taking

the term elderly to mean men of 65 and over and women of 60 years of age and over, about 18% of all the elderly in the administrative county are getting free chiropody treatment.

The chiropody scheme was begun with the intention that it should be staffed by full-time employees of the authority but in the beginning such staff were not available. Arrangements were, therefore, made with chiropodists in private practice for them to treat patients either in their own surgeries or in clinics, and to give such domiciliary treatment as was authorised. As full-time staff became available they were appointed and at the beginning of 1966 there were three full-time chiropodists in post. By that time many of the fifteen chiropodists in private practice who were treating patients under the county's scheme had case loads which required them to devote almost all their time to local authority work, although theoretically continuing to be classed as part-time officers because they were paid on a sessional or case basis. It also became clear that more full-time chiropodists could be recruited and the establishment of full-time staff was, therefore, increased to six. Mrs. G. Garrett and Mrs. D. E. Smart were appointed. The remaining post has been reserved for a former member of the authority's staff—a dental surgery assistant—who expects to qualify as a chiropodist in 1967. It also seemed opportune to review the case loads of the part-time staff and to re-consider the frequency of treatment. There were meetings with the chiropodists, following which it was decided that the maximum number of patients which a part-time chiropodist could have under the authority's scheme should be 350 and that the period between treatments should be increased from six weeks to eight weeks, although in appropriate circumstances Area Medical Officers may authorise more frequent treatment.

The result of this review of case loads and the transfer of patients from part-time staff to full-time staff where indicated resulted in a substantial number being removed from the register on the grounds that they no longer needed treatment regularly, or persistently did not keep appointments. The register of 5,745 patients on 31st December, 1966, is probably, therefore, a more accurate indication of need for treatment than has been available for a few years.

The staff at the end of the year consisted of five full-time members—Mr. G. W. Thomas, Mr. W. W. Gordon, Mrs. H. Coulson, Mrs. G. Garrett and Mrs. D. E. Smart—and thirteen part-time staff. On the assumption that 550 patients constitute a case load for a full-time chiropodist, the part-time members of staff are in total equivalent to 5.3 full-time.

Two new treatment centres—Cleator Moor and Salterbeck—were opened during the year and treatment is now available at the following places:—

Alston	Maryport
Aspatria	Millom
Brampton	Penrith
Carlisle	Salterbeck
Cleator Moor	Seascale
Cockermouth	Silloth
Egremont	Whitehaven
Keswick	Wigton
Longtown	Workington

Chiropodists also visit all the authority's Old People's Homes. Mr. G. H. Thomas, M.Ch.S., Senior Chiropodist, has submitted the following report:—

“There has continued to be a steady expansion of the service with a regular flow of new patients being referred and the return of other patients requesting further treatment, often after an absence of up to two or three years, who now require attention again. This is an encouraging sign as it illustrates that treatment, provided it is planned with a definite aim, can allow a patient to attain and maintain an optimum level of comfort and is not necessarily merely palliative nor repetitive. In view of the age of most of our patients many cases are chronic ones but planned long term case management enables one to reach a stage when only a watching brief is required.

"Nevertheless, concern has been expressed at the increasing case loads which, despite increasing the number of bookings per session and an extension of the time between visits, is throwing a very heavy strain on the operators. Priority is given to the more serious cases with an associated medical and/or surgical background but even so many patients are not receiving the full treatment they require.

"Suggestions have been made by which this problem might be alleviated but, in view of the financial restrictions which are necessarily being placed on the Authority, it seems unlikely that much can be done to put these into practice.

"I would only repeat what I have said on previous occasions, that the cardinal aim in helping the elderly is to maintain mobility and that very often it is the provision of chiropody treatment alone which prevents an elderly person from becoming house-bound or bed-ridden and thus needing other health or welfare services.

"Every effort is being made to effect economies in the service without lowering the standards of treatment and, to this end, wherever possible patients are provided with replaceable permanent or semi-permanent appliances instead of adhesive dressings which have limited usage. These appliances and alterations to footwear are carried out in the department.

"It has been arranged for those patients attending the Club for the Physically Handicapped at Whitehaven, who have previously been receiving domiciliary treatment to be treated in the clinic whilst at the Centre. This is in line with the policy of providing domiciliary treatment only where it is essential."

I believe that, despite the difficulties of running a service which has a substantial domiciliary element in a rural county such as this, a satisfactory chiropody service is being provided. In some of the more difficult areas the voluntary societies are co-operating in the provision of transport and indeed without this

co-operation a number of patients would have difficulty in getting to treatment centres. I would like to see voluntary sources extending their help by transporting those who now have to receive domiciliary treatment but who are fit to receive surgery or clinic treatment, provided that transport is available.

VENEREAL DISEASES

I am indebted to Dr. H. J. Bell, Consultant Venereologist, for his permission to publish the following extracts from his **Annual Report** to the Special Area Committee of the Newcastle Regional Hospital Board:—

For some years now the following Table has had a place in my Report:—

Year			Early V.D. Infections		Total Attendances	
			Carlisle	Whitehaven	Carlisle	Whitehaven
1956	...	...	60	23	909	450
1957	...	...	45	17	741	362
1958	...	...	45	22	806	301
1959	...	...	69	20	893	398
1960	...	...	74	20	920	472
1961	...	...	67	20	755	454
1962	...	...	70	52	640	473
1963	...	...	86	41	715	266
1964	...	...	84	56	635	284
1965	...	...	99	68	730	388
1966	...	...	79	61	742	443

“In ‘Early V.D. Infections’ I always include gonorrhoea, early infectious syphilis and cases of non-specific urethritis (non-gonococcal urethritis). This last condition is usually referred to as N.S.U. or N.G.U. Despite the steadily increasing numbers of N.G.U. patients in this country in the last fifteen years, the Ministry of Health is not yet prepared to list the condition as a Venereal Disease.

"It will be noted from the Table above that the figures for early V.D. infections fell in 1966. This is accounted for entirely by a reduction in gonorrhoea cases. At the Carlisle Clinic the reduction was from 71 to 46, and at Whitehaven from 55 to 32. It is frustrating to admit that I know of no reason to explain this—the first significant down-swing of a graph line which has been steadily rising in Cumberland for a decade—because no reliable prediction for the future can be inferred here. The statistics for the early months of 1967 suggest further up-swing. The Ministry's figures for all England and Wales show the same rapid uprise in the gonorrhoea graph between 1954 and 1961: thereafter there has been some minor oscillation since that year until the present year, leaving a general impression that a plateau has been reached. It has always been of interest to me to note that any new statistical phenomena in gonorrhoea or syphilis which occurs in the bigger English cities—especially London—does begin to reflect itself up here in the North some two to three years later. So, as far as gonorrhoea is concerned it may be, then, that the worst has passed.

"Examples of gonococcal ophthalmia of the newborn are showing up rather more often in our local obstetrical units, but the numbers are surprisingly small. When one remembers that gonorrhoea in women is most prevalent in the age group 19-24, and that this is the same age group commonly encountered in these units, one would expect to come across gonococcal ophthalmia much more frequently. Since gonorrhoea is, for the most part, an asymptomatic (silent) disease in women, there is likely to be no hint from the patient herself which will alert the midwife, or the doctor, at the Ante-Natal Clinic that she has the infection. Likewise, the presence of the disease is not likely to be disclosed during the normal routine investigations carried out at an Ante-Natal Clinic. The fact is that our methods of diagnosing gonorrhoea in the female are quite inadequate and out of date. Were 'screening' tests of the blood—such as the Wasserman and Reiter Protein Complement Fixation Tests for syphilis—available at Ante-Natal Clinics, the situation would change overnight and hundreds of cases of gonorrhoea would be brought to light every month in this country. So far there is no 'blood test' for gonorrhoea and the Gonococcal Complement Fixation Test I regard as useless.

"The problem of the 'sticky eye' in the new-born is one which seldom produces any great enthusiasm.

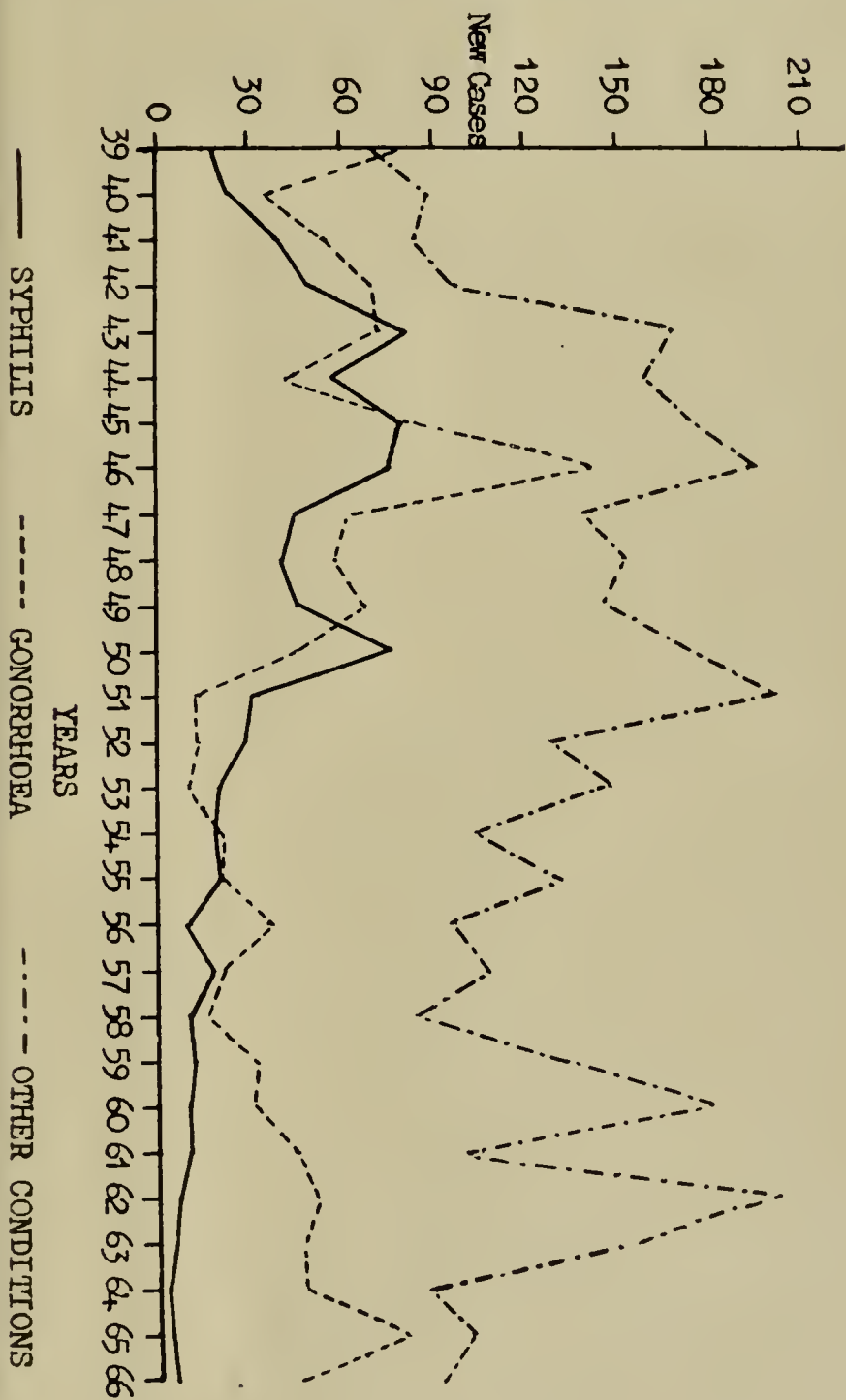
"I am frequently honoured by invitations from branches of the Royal College of Midwives to give lectures on the subject of my own specialty, and I never give up trying to impress on these ladies what a fascinating subject is the 'sticky-eye' of the neonate. Since 1965 the Ministry has required an annual return of gonococcal ophthalmia cases to be included in the statistics from V.D. Clinics. No doubt this will allow the Minister to have a cross-check on similar returns from the local Medical Officers of Health. How I wish there were some practical method of determining the true incidence of gonococcal conjunctivitis in the newborn in the country!

"In 1966 a great deal of time and effort was expended in organising advertisement of local V.D. Clinics. I touched on this subject in my Report of last year and referred to notices for Post Offices, Public Parks, Youth Clubs and the like. The focus of attention latterly was directed to helping lorry drivers. I undertook to make a personal approach to managers or owners of lorry-drivers' cafes on the road A.74 and A.6, between Shap and Beattock summits, where the main route between Scotland and England traverses my territory. My request was that a suitable notice should be displayed in these cafes. This notice simply drew attention to the times of the Special Treatment Clinics held in hospitals in the area, and gave telephone numbers of the hospitals. Liaison between Medical Officers of Health was both intelligent and swift. The notices are clearly printed and pleasant in appearance. They are formed in laminated plastic and reasonably indestructable. They are in course of being distributed by the local Public Health Inspectors (England) and the Sanitary Inspectors (Scotland). These inspectors will pay visits from time to time to ensure that notices are still on display, and will replace notices defaced or destroyed. Throughout all these negotiations I have had a good deal of thoughtful advice from the Editor of 'Headlight', the lorry-drivers magazine."

The Table following shows the origin of all new patients attending Cumberland Clinics in the year 1966:—

Town or Area					To Carlisle Clinic	To Whitehaven Clinic	Total
Carlisle and suburbs	...	...	...	...	113	—	113
Anthorn	...	...	...	...	1	—	1
Appleby	...	...	...	...	1	—	1
Aspatia	...	...	...	...	10	—	10
Brampton	...	...	...	...	4	—	4
Cleator Moor	...	...	...	...	1	2	3
Cockermouth	...	...	...	...	—	3	3
Dalston	...	...	...	...	4	—	4
Distington	...	...	...	...	—	4	4
Dumfriesshire	...	...	...	...	22	—	22
Egremont	...	...	...	...	—	5	5
Frizington	...	...	...	...	1	1	2
Holmrook	...	...	...	...	—	1	1
Kendal	...	...	...	...	3	—	3
Keswick	...	...	...	...	3	—	3
Longtown	...	...	...	...	3	—	3
Maryport	...	...	...	...	2	8	10
Millom	...	...	...	...	—	1	1
Penrith	...	...	...	...	11	—	11
Seascale	...	...	...	...	—	1	1
Silloth	...	...	...	...	7	—	7
Whitehaven	...	...	...	...	2	23	25
Wigton	...	...	...	...	6	—	6
Workington	...	...	...	...	12	31	43
Others	...	...	...	...	56	3	59
TOTAL					262	83	345

VENEREAL DISEASES—NEW CASES PER YEAR 1939 TO 1966
ADMINISTRATIVE COUNTY OF CUMBERLAND





WELFARE SERVICES



BRaille READER

WELFARE SERVICES

The changes dealt with more fully in other parts of this report in the field of the domiciliary medical care of sick and disabled people affects in a far reaching way the future of the welfare services also. Similarly, developments in hospital services for geriatric patients stand very closely related to the welfare services of the local authority, and in this connection I am most grateful to Dr. J. Kaminski, Consultant Geriatrician in West Cumberland, for a very thoughtful appreciation of our respective roles in caring for the elderly. In Cumberland the unification of health and welfare services came just when the momentum was developing on the first important step towards unified patient care in the community, viz. the attachment of local authority nursing staff to groups of general practitioners. This historical accident has created a situation which I believe to be of considerable advantage, and the domiciliary arm of the welfare services has been able to develop smoothly alongside the nursing services. It has become more apparent every day that the social welfare officer and the health visitor can, between them, supply the family doctor with a socio-medical service which enables him to properly orientate his medical practice in the direction of the increasing social component which it contains. It will be apparent from what I have said that I believe that a united health and welfare service has been successful in Cumberland and as the development of total patient care outside hospital has advanced, it becomes increasingly difficult to visualise the two services separately. It is true that it has not been possible because of the small number of officers involved to securely attach social welfare officers (who it must be remembered combine mental welfare duties with others) to group practices. Nevertheless in the geographical areas in which these officers still work in the main, their contacts and co-operation with family doctors has become close and their value daily more appreciated.

Still dwelling on the field work or domiciliary side of welfare services, there is no doubt that the next major turning point will be the outcome of the deliberations of the Seebohm Committee. Should this lead to the establishment of separate departments of social work within local government the course of the development outlined above may be very significantly altered, and I would

fear that this could very possibly be in the direction of fragmentation of a successful unified service. However there will no doubt be considerable discussion of this subject at all levels before major decisions are taken, and at the same time the pattern of health services in the country will be developing. This is but another facet of the period of rapid change with which all in health and welfare work are living at present.

Turning to the residential care of elderly people, the main single event in 1966 was the opening of the first home for more handicapped people in Whitehaven. One of the first points which became apparent here was that facilities thought of in the first place for this particular home really require to be reproduced in all homes being built. This is but another way of drawing attention to the fact that the level of disability and frailty being managed today in the old people's homes is far in advance of what was thought of only a few years ago. The contribution of special housing schemes (there are now 10 supported independency schemes providing 242 tenancies in Cumberland) has no doubt contributed to this situation, plus the fact that short stay periods in hospital or indeed in an old people's home enable more people to retain their own homes until a quite advanced stage of frailty has overtaken them. This might be thought at first glance to contribute to a reduction for demand in places in old people's homes, but at best it can be said to keep the waiting list to not unreasonable proportions.

As each new old people's home is opened in the county the more anachronistic do the remaining two ex-public assistance institutions seem. It is good to anticipate the closure of one towards the end of 1967 and the other within 2 years thereafter.

Progress towards a planned continuum of care for elderly people becoming daily more frail is the only rational way to manage the problem, and I have been greatly encouraged in 1966 by the developments already referred to in the home care of the elderly and sick on the one hand, and on the other by developments in co-operation with the hospitals. I particularly refer to the matters Dr. J. Kaminski (Consultant Geriatrician) describes in the following report:—

"The efficiency of a hospital geriatric service and the value of such a service to the community depends to a great extent upon the efficiency of the other departments of the health service, General Practice and the Public Health and Welfare Departments, and only the full co-operation and liaison between these services can assure the full and best use of the facilities available for the welfare and health of the elderly.

"In West Cumberland the hospital geriatric service has a relatively short history. For years there had been beds for the elderly chronic sick, where custodial care, but no active treatment was provided. These beds were usually in the oldest and least suitable accommodation. There was also a great shortage of technical staff and most of the nursing was done by unskilled personnel. The emphasis was on care and not on treatment.

"With the building of the West Cumberland Hospital this situation changed. With 60 geriatric beds in the new hospital, in the first wards to open, the medical care of the elderly sick acquired new dimensions. It became apparent to those working there that with an active approach to illness in old age, many elderly sick, even those with severe physical disabilities, could make sufficient progress to be resettled back in the community, where they wanted to be. Moreover, it became obvious, that only by treating all conditions present, physical, social and psychological, could a good response be achieved.

"It was also realised that this active approach to the medicine of old age is very time consuming and requires good allocation of staff, medical and nursing and many auxiliary services such as Physiotherapy, Occupational therapy and the department of Medical Social Work.

"The more active the work of a hospital becomes, the more it must rely on the full liaison and support of other services. The majority of elderly patients leaving the hospital require, apart from the attendance of their family doctor, some degree of community care. Only with such help can they maintain their independence. The degree of care needed depends on the patient's medical condition and his home conditions. Some require the

support of their families only, while for others it may be necessary to draw on all the resources of the domiciliary services. Some patients can not manage themselves at home even with the full support of such services and require admission to a residential home for the elderly.

"There is no local Authority in this country able to meet all the existing needs of the elderly population. Each one is short of resources of one kind or another, just as each hospital authority is limited in the standard or the variety of service it can provide. To measure the value of any such service, one must assess not only the resources it commands, but what is more important how they are being used.

"In the last few years a great deal of progress has been made by the County Health and Welfare Department in every sphere of its activity. In the same way as the hospital service, it was short of resources of every kind and burdened with the relics of the past—the large, depressing ex P.A. institutions, no longer acceptable to the modern society. More important, it was short of trained personnel with the modern approach to the care of the elderly.

"This then was the initial problem. The achievements most relevant to the care of the elderly are the new, high standard residential homes, replacing the old institutions, the recruitment and training of staff, both nursing and welfare, the expansion of services such as Home Helps, Meals on Wheels, Luncheon Clubs, Chiropody and others. The Public Health Department also advocated and supported several special housing schemes so important in maintaining the elderly within the community.

"This increase in facilities available for the elderly is having an impact on the hospital service. It is much more practical now, with the full support of domiciliary services, to maintain frail elderly people at home. This in turn lessens the demand for hospital accommodation, shortens the waiting time for admission and the length of the patient's stay in hospital. More important, it is now much easier for the elderly patient to be admitted when he becomes ill, and not weeks later, thus giving him a much better chance of recovery. These developments also affect the character

of the work of the Health and Welfare Departments. There are now many more frail elderly people within the community who need care and attention.

"People accepted now for residential accommodation are much frailer, than were their predecessors only a few years ago. This has increased the load of work for the staff of residential homes and requires a new approach to cope with a new situation.

"To deal efficiently with the day-to-day care of the elderly and also to plan the future development of both services, the Public Health and Welfare Department and the geriatric department of the hospital have established close liaison at all levels.

"For some years now the Area Nursing Officers have been attending weekly medical rounds in the geriatric department followed by a case conference. Here they meet the medical and nursing staff, the medical social worker and the physiotherapist. They take part in discussions about the patient's condition, prognosis, degree of recovery which it is hoped to achieve and the amount and kind of domiciliary care which may be needed after discharge. The contribution of area nursing officers to these meetings is a very important one as they usually have a lot of information about the patients, their background, and the attitudes of their families. They also gain a lot of information which is essential to them in order to mobilise the services necessary for the patient once discharged home. Here the final details are arranged for the follow-up services of Health Visitors, District Nurses, Home Helps, Meals on Wheels and others. Meetings of this kind, apart from their direct practical value are very helpful to all participants by giving them a deeper insight and appreciation of the problems facing different parts of the service.

"During the last year further progress has been made in improving liaison, by introducing monthly combined meetings of welfare officers, area medical officers of health, geriatricians, and the medical social workers. This is a working meeting during which the waiting lists for welfare accommodation are brought up to date and urgent cases discussed. By an exchange of information all gain a better understanding of the specific problems of the elderly people discussed.

"These meetings of nursing officers and welfare officers with hospital workers are of great value. They create a team spirit and help to teach each participant his own role in the service. Only when this is appreciated by all, can a truly comprehensive service become a reality.

"The last development in improving liaison between the services has been the establishment of monthly meetings between the County Medical Officer of Health, Welfare Services Officer, Psychiatrist and Geriatrician. The purpose of these meetings is to discuss and take decisions on current problems and to plan the future development of each service.

"With the increasing number of the elderly frail people within the community the demand on services they require will multiply. To meet this demand in West Cumberland it will be necessary to provide more facilities and also to look for new ways in which to approach this ever increasing problem.

"Of the services which need further expansion the Home Help Service is one of the more important. The provision of Meals on Wheels should extend to supply not only more elderly people but also to operate on a more days per week basis; to do this it may be necessary to consider if the resources of the voluntary organisations are large enough to meet this problem. The local housing departments could help a lot to supply suitable housing by further development of special housing schemes for the elderly.

"With the adequate provision of these facilities more and more elderly people will be able to retain their place within the community and the community itself will take a greater part in looking after the elderly."

In the following paragraphs, Mr. S. Hodgson, Welfare Services Officer reviews some of the changes in the course of his 44 years in the welfare service.

"The Public Assistance Committee constituted by the Council to deal with their statutory duties under the Local Government Act 1929 first met on the 5th December, 1929. Soon after, the Poor Law Act 1930 came into force on the 1st April, 1930, and on this

date the Committee inherited from the former Boards of Guardians 7 institutions, 5 children's Homes and several relief and registration officers; the 7 institutions were accommodating 461 persons. It became immediately necessary to develop residential accommodation to meet the requirements which were then considered necessary in 1930. Inspection of the institutions in the County resulted in the inevitable conclusions that the buildings were not satisfactory and in the next decade 4 were closed, leaving Station View House, Penrith, Highfield House, Wigton, and Meadow View House, Whitehaven, continuing to function. The Committee continued its work until 1948 in a progressive manner and did all that was possible with limited financial backing to break away from the institution of tradition by improving accommodation for those people in their care.

The Welfare State

"The National Health Service Act 1946 resulted in the transfer of local authorities' responsibilities for the administration of hospitals to Regional Hospital Boards. The predominant user of our three remaining institutions was the County Council as public assistance authority and consequently the hospitals remained the property of the County Council who continued to administer the hospital blocks as agents for the Hospital Board.

"The National Assistance Act 1948 transferred the responsibility for the payment of outdoor relief and for casuals to the National Assistance Board. Under this same Act, local authorities retained their own responsibilities for providing residential accommodation for the aged.

"A further piece of legislation—the Children's Act 1948—resulted in the appointment of a separate standing committee and for a separate department to be set up.

"As is well known, institutional care was provided in work-houses erected in the 19th Century as a positive deterrent to those seeking poor relief, but with the creation of the welfare state, destitution was no longer the criterion for admission.

"Whilst Poor Law had been so much in disfavour, there was some regret when it was finally broken up. The disappearance of the relieving officer with his statutory duty to relieve destitution meant the end of a common point of referral for many problems. Valid criticism also arose from the fragmentation of services for the old people which left an awkward dividing line between hospitals and welfare authorities.

"Four years ago, Meadow View House, Whitehaven was closed. Within the next 2-3 years the remaining two workhouse buildings will also be closed which will bring to an end this type of accommodation and all of our residents will be provided for under modern Home conditions.

"Mention has been made in previous reports of the integration of the Health and Welfare departments, and a developing unified service is being created. This being so the disappearance of the relieving officer is no longer mourned."

The above condensed summary of events over the years by Mr. Hodgson, spans a period of constant change and development of welfare services. It does not of course reflect the tremendously important part that Mr. Hodgson personally has played during this period in Cumberland, something to which I will be making further reference in my next Annual Report, since Mr. Hodgson's well earned retirement takes place in 1967.

There is no doubt that the welfare services for the elderly and the physically handicapped have continued to progress generally during the year.

Growing old means a gradual decline of faculties bringing with it a growing dependence on others. There are over 6 million people in the country over the age of 65 and nearly a quarter of them are living alone. In Cumberland the population aged 65 years and over was 26,720 in 1965 and this is estimated to increase to 32,000 by 1967; this increase in numbers calls for an expanding service.

Old age is inevitable but not all the tribulations which accompany it are. Most of these are by now well-known but there

is still a basic need for more research. As mobility and re-deployment of labour tends to advance in industrialised areas, an increase in the proportion of aged people who are left incompletely supported by their families can be expected. This in addition to the 4½% of people aged 65 and over accommodated in Homes and hospitals is a heavy responsibility for the welfare services.

When the provision of supported—independency dwellings was being introduced it was thought that the result would be a diminution of the demand for beds in Welfare Homes. Similarly the meals-on-wheels service was regarded as a supporting factor in enabling the elderly to continue to live an independent life within the community. These measures, however, at most only delay ultimate admission to Old People's Homes.

A continuum between hospital geriatric wards and Welfare Home accommodation is widely accepted professionally and is the basis of regular active liaison between local authority and hospital staffs. There is now also a very valuable link with the attachment of nurses to general practitioners.

Close contact is kept with all the voluntary organisations in the County and this is referred to in more detail later in this report.

It is 5 years since the Health and Welfare Departments were amalgamated. During this period also mental health and welfare services were brought together as one unit, so that we have progressed from a welfare service operated by part-time officers who held other non-departmental appointments to a service operated by full time officers, there now being in each area a team of social welfare officers under the leadership of a senior officer professionally trained.

Periodic meetings of the staff of Homes and field workers are held and there is a close integration of services and a valuable and comprehensive link between all the officers within the health and welfare department.

Emphasis is however on the need for more research in this important work of caring for our elderly population. The possibility has been previously considered of compiling a register of

elderly people living at home, which would be of value to all of the social agencies with responsibility for helping them. Pilot projects have been established in two areas of the County, based on two group practices, one in the East and one in West Cumberland, where a list of people over seventy years will be compiled from the practitioners' records, and an assessment made of the care and attention required.

Publicity has recently been given to the probability of the Ministry of Labour setting up a Government Training Centre for unemployed and unskilled persons and a site in Maryport has been suggested. If this comes about it will be of particular interest in that a residential Home for younger handicapped people (with workshop facilities) is now being built by the County Council in Maryport.

In 1965 the County Council approved the setting up of a second Working Party to consider the needs of the aged in Cumberland.

Meetings were held on thirteen occasions during the year and evidence was given by Hospital Consultants, general practitioners, representatives of district councils, Matrons of Homes and voluntary organisations.

It was decided at the outset that this Working Party should regard its task as mainly in the nature of a review of the work of the first Working Party which reported in 1959; and that these reviews should probably be conducted at five-yearly intervals.

The review took the form of an exploration of those topics on the care of the elderly which are currently of major importance or whose development since the last report has involved fresh lines of thought and indicated the need for new guidelines for the future or extensions of those previously recognised.

This task has now been completed and the Party's full report and findings are soon to be considered in detail by the Health, Housing and Welfare Committee.

At this stage it is probably sufficient to mention that the report is arranged in the following sections:

1. Special Housing for the Elderly.
2. Residential accommodation in Old People's Homes.
3. Domiciliary Services.
4. Mental Health.
5. Meals for Old People.
6. Preventive Health Measures.
7. Family responsibility.
8. Voluntary services.

Residential Hostels

The provision of Hostel accommodation is continuing to develop although there has been delay because of the general financial position.

During the year one new Home with 40 beds was completed in Whitehaven.

The number of beds in Part III accommodation at 31st December, 1966 was

Ex-public assistance institutions	...	117
Homes in adapted premises		114
Purpose-built Homes		189
		420

Building has commenced on a new Home (10 beds) at Aspatria (in association with a supported independency scheme) and will be completed in May 1967. At Maryport a Home for the younger handicapped (20 beds) will be completed in January, 1968, and Homes for the elderly at Penrith in February, 1968 and Longtown in March, 1968.

Further schemes at Keswick and Millom are in the 'pipe-line' and building is scheduled to begin in 1967/68.

The new (40 bedded) Home at Penrith will mark the closure of Station View House which has been occupied in the first instance as a workhouse under the Poor Law regime and latterly as an Old People's Home. There will thus remain only one ex public assistance institution in the county at Highfield House, Wigton and this is due for closure in 1968/69.

The waiting list has fallen very slightly and stood at 79 at the end of the year. As much of the demand for places is from the Western and Southern areas it has been decided to substitute a Home for 40 at Workington instead of Dalston and this will be in 1968/69 programme.

The growing interest in the welfare of our residents continues and several organisations act as Friends of the Homes. As a result of their activities considerable amounts of money have been raised for the benefit of the people in our care.

A further link with Poor Law was broken when it was decided to discontinue the free issue of tobacco and sweets to the residents of our Homes. In substitution, a monetary contribution is now made to the "comforts" fund at each Home, which has the merit of being available for the benefit of all residents and not a selected few. This decision which created much discussion at the time has been generally accepted and has not created any hardship for anyone.

I am grateful for the following report which has been received from Mrs. E. Lowry, Secretary of the Friends of Station View, Penrith.

"The aims are to give the residents of Station View House a feeling of belonging to the community by:—

- (a) Co-ordinating the present voluntary work.
- (b) Extending this work.
- (c) Exploring new fields of work.

"As a preliminary all the members of the committee visited the Home and met the residents with the Matron.

"Following this those residents without friends or relatives to visit them were allotted to members of the committee who now visit them regularly. Small gifts are taken and one member has held a teaparty at her home for four of the ladies.

"Some form of entertainment is devised each month. So far we have had a visit from "The Friars" (an excellent singing group including members of the Savoyards), a conjurer and community singing; the Girl Guides gave a concert and the Evergreen Concert Party also entertained them.

"During the summer months it is hoped to arrange outings for the residents, either collectively or individually.

"Just before Christmas, when it was felt it might be more welcome than over the Xmas festivities arranged by the staff of the Home, the ladies of the committee made mincepies which were delivered just in time for them to be heated and served with the 3 o'clock cup of tea; this proved a great success. Each resident was sent a Christmas card—this again was welcomed, as some of them never received a card even at Christmas time.

"Matron organised an 'Open Day' and Bring and Buy Sale which was opened by Lady Lonsdale. The Friends agreed to finance this by paying for the printing of the drawing tickets, the newspaper advertisements, etc., giving the tea and biscuits, serving same and helping generally behind the stalls on the day. The Comforts Fund of the residents benefitted considerably.

"No financial appeal has yet been made, though we have received donations from several organisations in the town. The concentration has been in creating a friendly atmosphere with the residents. The female residents have responded well so far; with the exception of a few of the men, the male residents are proving difficult to befriend. This problem is being explored and it is hoped it will soon be resolved."

Mrs. Wilson, Matron, has sent in the following report regarding Brackenthwaite (Whitehaven), the Home for the more infirm which opened during the year;

"Brackenthwaite received the first residents in July 1966, and the majority of them appear happy in their new environment.

"Daily luncheons commenced in October; the 30-35 persons who attend each week enjoy coming and mix well with the residents.

"Meals on Wheels have now resumed and cater for 32 people; voluntary helpers do the washing-up.

"Mrs. Melville, handicrafts teacher, comes each Tuesday morning; although the class is small, a fair amount of work is completed i.e. fireside rugs, chair-back covers, dish cloths and individual sewing bags. Mrs. Melville hopes to exhibit some articles later this year.

"A 'Friends of Brackenthwaite' group has been formed which so far has been successful in providing extra comforts for the residents e.g. an electric fire, foot stools and radiogram to mention a few.

"We have girls 14-15 years old coming from the local secondary modern school on a voluntary basis to help at meal-times and do shopping for the residents. The residents themselves are mostly frail infirm people; even so some do help in a small way around the Home."

The Matron of one of our latest Homes, Moot Lodge, Bramp-ton, contributes the following:—

“The past year has been an interesting one for me personally at Moot Lodge, meeting old people with backgrounds of country life and service so different from that of the old cotton mill workers and foundry hands of industrial Lancashire, where I worked previously. Their characters and their outlook are so different, even their ailments.

“General health over the year has been on the whole quite good and in one or two cases even showing an improvement, but a slight increase in mental confusion has been noticeable. Here there would appear to be no hard and fast observations as we have a lively, alert, interested 92 and a prematurely senile 73. There is the closest possible liaison between the Home and the local doctors and district nurses and there have been offers of voluntary help from local Red Cross members.

“Family visitors are quite consistent, in the main coming regularly if, in some cases, not too often. There are a few residents who have to rely on family letters, but perhaps this is understandable in a county where so many people go away to find employment. Still, even in these cases residents are often visited by their own old friends.

“We have tried to bring more general visitors into the Home and now have regularly a Young Methodist Group and men from the Society of St. Vincent de Paul. A group of clergy and laymen from the diocese have discussed with me how best their services can be utilised but unfortunately progress is slow in this direction. Schools too are becoming much more interested and we have exchanged visits during the year with the girls of the senior school. Christmas was very successful with visits from parties of school children to sing carols and read lessons and they also gave us their own decorated Christmas tree. Arrangements have been made for a senior Grammar School boy to come in to read to a lady who is particularly poor sighted. We have also had film shows ranging from Morocco to Germany.

"I have found it difficult to raise much enthusiasm for organised card games and the like, with excuses as many and varied as the people making them. However, we press on, hoping that one day perhaps just one person showing a spark of enthusiasm may encourage others.

"We have had outings over the year but unfortunately it is the same people who go every time, the more infirm finding it too difficult to mount and dismount even modern coaches. Perhaps in Cumberland one day we will aspire to a converted bus with the emergency door at the back equipped with a lift to take wheel chairs, and having seats down one side only, leaving chair room down the other.

"A side of the Home which I find very encouraging is the Day Care Centre. We are lucky in having four wonderful old men on four days of the week, who contribute more to the place than they take from it. They bring life and interest to the house-bound and take part in our activities as part of the family.

"Since November we have provided 48 meals per week for the Meals on Wheels Service, fortunately with a minimum of teething troubles. I understand from the Health Visitor that they now have a waiting list for this service."

The Homes continue successfully to provide lunch club and day centre facilities which are very much appreciated by those attending; six day centres and four luncheon clubs provide 9,700 meals annually.

The pursuit of hobbies continues and there is a nucleus of residents in each Home who have found some measure of happiness as illustrated in the following report from one of the residents at Richmond Park:—

"The residents of Richmond Park Home are very happy to have Mrs. Melville as tutor in such a variety of subjects. Her patience is superb and we no doubt cause her many headaches.

"We have knitted dish-cloths, oven-cloths, hot water bottle covers and bath mats, all from nylon—a difficult fabric to knit. Shopping bags, slippers and coat-hanger covers have also been made. We enjoy too, the making of many humorous animals from fur fabric. Basketry, tapestry and knitted blankets, and chair and table covers worked on 'Binea' decorate the Home. We hope that this year's exhibition entries do as well as they did in former years."

As in previous years a holiday was arranged and 68 residents (including staff) went to Morecambe for a week (26 stayed in a holiday camp and 42 were accommodated in private hotels).

There was an exchange of residents with those from Homes administered by South Shields County Borough Council and eight residents greatly enjoyed a fortnight at South Shields.

At 31st December	No. of beds provided			No. of Residents		
	Joint-User Establish- ments	Modern type Homes	Total	Joint-User Establish- ments	Modern type Homes	Total
1949	375	—	375	235	—	235
1950	375	—	375	238	—	238
1951	325	—	325	243	—	243
1952	325	—	325	217	—	217
1953	325	19	344	201	18	219
1954	325	19	344	219	19	238
1955	263	69	332	188	57	245
1956	263	69	332	189	70	259
1957	242	69	332	188	65	253
1958	242	87	329	193	88	281
1959	252	108	360	199	99	298
1960	215	146	361	174	132	310
1961	215	146	361	178	132	310
1962	117	230	347	93	208	301
1963	117	230	347	112	222	334
1964	117	229	346	114	218	332
1965	117	264	381	116	254	370
1966	117	303	420	114	282	396*

*348 of these residents were aged 65 years and over.

As mentioned previously the meetings of Matrons are held periodically where various aspects of the Homes are discussed such as "Friends of Homes", amenity funds, trainees, staffing of residential Homes, and staff accommodation.

During the year a system of unit costing has been introduced to secure a more effective form of control of expenditure in welfare Homes, and this costing system has been explained to the Matrons by a representative of the Finance Department. Quarterly statements are prepared for each Home which indicate the trend of expenditure and the Matrons can compare the actual costs against the budget estimate, current costs with those of the previous quarter and the expenditure in their Home with that of similar Homes.

Temporary Accommodation

This is provided in a building within the grounds of Highfield House, Wigton giving accommodation for three family units; and in one house at Harriston, Aspatria.

The main purpose of this accommodation was the temporary housing of problem or evicted families to avoid the possible break up of families. There is co-operation with housing authorities prior to eviction and in some cases with a rent guarantee system. Efforts to prevent eviction have been successful. The tendency is, however, for families to remain in occupation of 'temporary accommodation' for much longer periods than was originally intended.

The work of rehabilitation linked with the Children's Department continues; selected home helps, who have received in-service training to enable them to function in a way which approximates to the work of "family service units", continue to provide a very useful contribution in this sphere.

Considerable difficulties are experienced in re-housing these families, but I am afraid that this problem will remain with us for some time.

At Wigton there are, and have been for most of the year, families comprising 6 adults and 14 children and at Harriston one family comprising 1 adult and 4 children.

Efforts are being made to acquire further sub-standard houses particularly in the western and southern areas to supplement our present provision. Meantime measures to improve the play facilities, as well as the safety, of the children in the Wigton units, are going ahead.

Staffing

There still persists a difficulty in filling vacancies for the post of Assistant Matrons but despite this, and the fact that the people for whom we care are becoming increasingly frail, there has been no flagging of interest and staff/resident relationship is very good indeed; whenever possible arrangements have been made for staff to attend training courses.

On levels of staffing in the residential Homes, a committee appointed by the National Council of Social Service (under the Chairmanship of Lady Williams) is at present considering recruitment, training and staffing in old people's Homes, and will shortly provide valuable guidance on these problems. The ratio of residents to staff in the county Homes differs according to the size and type of Home—in general the ratio is about $3\frac{1}{2}$ to 1.

The introduction of a trainee scheme has I think been a success and well worth while.

Private Disabled Persons' or Old Persons' Homes

There are now four registered private Homes in the County—

Stoneleigh, Gosforth	11 persons
Rothersyke, Egremont	20 persons
Scalesceugh, Near Carlisle	25 persons
Spring Bank, Braithwaite	10 persons

There was a change of ownership at Rothersyke, Egremont and the accommodation at the Home at Scalesceugh has now been increased from 25 to 30. These Homes continue to be inspected by the staff of the department.

Accommodation Provided on Behalf of the Council

By arrangement a local authority may provide accommodation for a person ordinarily resident in the area of another authority. Accommodation is also provided by voluntary organisations.

Thus, on the 31st December, 1966 there were 15 men and 9 women accommodated in such Homes:—

Local Authority Homes	Men	Women
Brigg, Lincolnshire	1	—
Steeton, West Riding	—	1
Stannington, Northumberland ...	—	1
Lime House, Wetheral	1	1
Staveley, Westmorland	1	—
Hoylake, Cheshire	1	—

Voluntary Homes

British Legion House, Ripon ...	1	—
Percy Hedley Centre, Newcastle ...	2	1
Maghull Home, Liverpool	3	—
Scalesceugh Home for Spastics, Carlisle	3	1
Home for Distressed Gentlefolk, Harrogate	—	1
Eothen Homes Ltd., Gateshead ...	—	1
Ernest Ayliffe Home for the Deaf, Leeds	1	—
Methodist Home for the Aged, London	—	1
Langho Colony, Blackburn	—	1
Enham-Alamein Village Centre, Enham- Alamein	1	—

Supported Independency Schemes

Past experience has brought about many improvements in the housing services made available for old people. The concept of the type and standard of services to be provided has changed considerably, particularly over the past few years since the introduction of grouped dwelling schemes provided by the housing authorities in association with communal and welfare facilities. Convenient, warm and supervised, these flatlets or bungalows are a haven in which an elderly person may enjoy security coupled with a personal key and her own furniture. This type of accommodation is now generally regarded as extremely valuable in community care.

This change in outlook brought about the need for a review of the scheme made by the County Council in 1959, for financial aid to local housing authorities in providing these grouped dwellings of supported independence, to bring it into line with present-day thought and generally to simplify the financial arrangements. Consequently a revised scheme was submitted and accepted by the working party on the Needs of the Elderly; the scheme will come into effect in April, 1967.

During the year two schemes, each with 24 places, opened—these were St. Michael's Court, Workington and Wyndham Court, Cleator Moor. These schemes are provided or planned by all housing authorities in the county except one rural district which is investigating the possibility of so-called "mini-schemes" in two villages, where a small number of flatlets would be provided and linked with existing bungalows.

Handicapped and Disabled Persons

The number of registered handicapped persons has increased by 102 during the past twelve months. The numbers registered and their classification is shown in the table on page .

It is very interesting to note that 1966 has seen an increase in the number of registered handicapped persons of approximately twenty five per cent and it is worthwhile considering the likely reasons for this. I have little doubt that one of the main factors is the close integration of all health services and the many secure links which now exist between family doctors and local authority field staff. This refers to the nursing staff and also to the social welfare officers. Everyone has a greater awareness of the potential benefits to a handicapped persons of being registered. Another factor is, no doubt, the development of clubs for handicapped people; this has done much, not only to draw the handicapped together where they share mutual experiences and difficulties, but to bring some into really effective contact with the welfare services for the first time.

It is also interesting to note that the main classes represented in this increased registration have been those persons who have undergone an amputation; who suffer from arthritics and rheumatic conditions; or who suffer from organic nervous diseases such as disseminated sclerosis or the effects of a stroke. It is true that these are amongst the largest groups of handicapped persons any way but it is pleasing to note that most of them are now coming within the full ambit of the welfare services.

HANDICAPPED PERSONS

	Persons aged 16—64		Persons aged 65 and over		Total	
	M.	F.	M.	F.	M.	F.
Amputation	27	4	12	10	39	14
Arthritis and rheumatism	13	23	13	25	26	48
Congenital malformation and deformities	31	16	9	1	40	17
Diseases of the digestive and genito-urinary systems; of the heart; of the circula- tory system; of respiratory system (other than tuberculosis) and of the skin	30	8	17	12	47	20
Injuries of the head, face, neck, thorax, abdomen, pelvis or trunk. Injuries or diseases (other than tuberculosis of the upper and lower limbs and of the spine)	41	6	20	5	61	11
Organic nervous diseases; epilepsy, dis- seminated sclerosis, poliomyelitis, hemiplegia, sciatica etc.	66	40	27	15	93	55
Neurosis, psychoses and other nervous and mental disorders not included above	7	8	1	1	8	9
Tuberculosis (respiratory)	3	—	—	—	3	—
Tuberculosis (non-respiratory)	7	3	—	—	7	3
Diseases and injuries not specified above	9	2	3	2	12	4
TOTALS ...	234	110	102	71	336	181

Now that more names appear in the register more applications are being received for adaptations to houses and the budget provision for this has had to be increased. Two examples of the type of adaptation carried out are—a) provision of handrails on both sides of steps and (b) flagging section of garden and ramping of kerb for erection of garage for a motor propelled tricycle.

As a result of joint efforts by statutory and voluntary personnel the Whitehaven Handicapped Club opened in September at Flatt Walks; with the assistance of the Social Welfare Officers the club is organised by the Ladies of Mirehouse and Whitehaven Townswomen's Guilds. The following report about the activities of the club has been received from Mrs. E. M. Benson, a member of the Townswomen's Guild:—

"This Club was opened on the 19th September, 1966, with eight members, and the ladies of the Mirehouse and Whitehaven Townswomen's Guilds helping. Monday is social afternoon and Thursday handicrafts afternoon, but we have made no hard and fast rules.

"On Mondays 'Stop the Bus' claims most of the members, but quite a few are keen on painting and making soft toys, so they just do as the wish.

"Our membership is now twenty-six.

"After only eleven weeks we held an Open Day. The Mayor of Whitehaven (Councillor Welch) attended and we also had Border T.V. and the press giving us much photographic coverage and publicity. Taking into consideration the bad weather we had that day, we did quite well, making about £45 selling the articles made by the members. Since then we have delivered many orders and we are now more or less self-supporting."

The Cumberland Council of Social Service organised two holidays for the disabled—at Middleton Towers, Morecambe and a Prestatyn Holiday Camp. The holiday in North Wales was very successful and was fortunate in having indefatigable workers in Mrs. Ellwood, Miss Hall, Mrs. Connolly, Mr. Husband and three young St. John's Ambulance men and the I.V.S. volunteers.

The situation regarding the physically and mentally handicapped people in the Northern Area of the County is given on the following report by Miss Welch, Senior Social Welfare Officer:—

“A large proportion of social workers’ time continues to be spent on elderly people living alone, and this will continue to be necessary. It takes time and several visits to begin to convince old people that they are not really able to look after their own affairs, especially because when they are at home neighbours and relatives go to a great deal of trouble so that the old person shall not be neglected, often at the expense of time spent with their own families. It is only when these supports are withdrawn that it is realised how little an old person can manage alone, and we are often in the frustrating position where supportive services are being provided to keep an old person in the community who might be much better off in a welfare home. Even the initial steps of attending day centres or luncheon clubs have to be ‘sold’ over a period of time.

“Clubs for the physically handicapped continue to flourish. When these were originally started our idea was to ask a teacher to run the group with the help of one or two voluntary workers, and once the club was thriving for the Welfare Officer to gradually withdraw, only looking in to collect money for meals or articles completed and to iron out any of the small difficulties. With practical experience we find that this has not been possible. The Club members have been more seriously disabled than we had envisaged and therefore need more physical help. The voluntary help we have been able to get has been mainly that of children in the higher forms of the secondary modern schools, who willingly make tea and fetch and carry for the club members, but who could not be held responsible for money or for lifting or supporting badly disabled people. The Wigton club has particularly flourished, being the only one which continues all day. Members are becoming expert in tray and basket making. They spend half their time in social activities such as dominoes, and get much pleasure from each others company. In addition to tray and basket making, other clubs are making soft toys, rugs, embroidered articles and woven goods, according to the interest of the various

members and perhaps a little to the particular skill of the teacher concerned.

"All the clubs are beginning to look forward to activities such as Christmas parties and summer outings. Because of their handicap these have to be organised by an outside fit person and it has fallen to the Welfare Officer to do this. The Longtown club has recently been conveyed to Brampton to meet its counterpart, and a return journey is proposed round about Easter time. These excursions are usually arranged with the help of Welfare Officers' and teachers' cars and any voluntary transport which can be managed. A suggestion has been received from Penrith Club for the Blind and Partially Sighted that they would like to see the film in Carlisle 'The Sound of Music' and again Welfare Officers will provide the transport. These activities are so much anticipated and so help the outlook of people confined to their homes for most of their lives that they are well worth doing. At the same time the Welfare Officers are getting to know individual members and their home problems and are often able to help to alleviate the stress which arises at home.

"The scheme for a week's holiday for physically handicapped people organised by the Council of Social Service is flourishing and would grow every year if places were available in suitable holiday camps. It seems that only one camp really caters for badly disabled people and only a few chalets can be allocated for the use of Cumberland patients if other areas are to have a fair share. Our next object may well be to contact a Butlin's or other well-known camp to see if we can extend the scheme.

"We still lack work which could be done by physically handicapped and mentally subnormal people. We need a continuation of progress towards full-time work for those who become capable through physical improvement or developed skill.

"Our main concern in mental illness is that of senility, either in welfare Homes or in the community, and our aim continues to be to keep these people out of hospital for as long as possible, though this can cause a great deal of anxiety on the part of Matrons or relatives who are trying to deal with the problem.

“Cases referred to our Department by general practitioners tend to be those which are a burden to the patient being treated i.e. an elderly patient who needs a lot of help, a handicapped child or adult who is becoming a burden or for those who are in failing health, when recommendation is made for supportive help such as home helps. In this way Welfare Officers probably become involved with more families than was at first envisaged on the purely practical plans. While these problems can take a good deal of time, we do at least gain an entry into many homes where we then have an opportunity to pick up the other difficulties which exist, in relationships and capacity to adapt, work availability and limitations, etc.”

Mr. Mossop, Superintendent of Distington Ambulance Station has sent in the following report regarding the transport of patients to handicapped clubs etc:—

“As far as this work is concerned in the Western and Southern Area, the bulk of these handicapped patients are conveyed by the Ambulance Service; in fact this is part of our daily routine at Distington and its satellite stations. The number of patients transported into handicapped clubs and day centres has more than doubled itself during the past year—the average number of patients conveyed being about 300 per week; due to the lack of specialized transport this can however become a major issue if a reasonable time schedule has to be maintained. A word of thanks of course must be given to the staff employed at the various centres for their co-operation in the efficient reception and despatch of the patients.”

Blind and Partially Sighted Persons

The total number of registered blind persons decreased by 22 during the year, although 57 new cases were certified blind. This comes about because as many as 79 were removed from the register during the year, mostly following death, but a few removed from the area and a few were certified as no longer to be regarded as blind.

It is interesting to note that in the past two years, the total number of blind people registered has shown a decrease. This has been associated with a slightly lower figure of new certifications each year.

The total number of registered partially sighted persons increased by 13 in 1966. This was associated with the addition to the register of 31 new cases.

Approximately two thirds of the new blind cases were over 65 years of age and approximately half of the new partially sighted cases.

The following table shows the age groups of blind and partially sighted persons registered on 31st December, 1966.

Age Group		Blind			Partially sighted		
		M.	F.	Total	M.	F.	Total
0—1	...	1	—	1	—	—	—
2—4	...	—	—	—	—	—	—
5—15	...	4	3	7	8	5	13
16—20	...	2	—	2	7	4	11
21—49	...	29	18	47	14	11	25
50—64	...	34	36	70	11	14	25
65 and over	...	128	228	356	34	61	95
TOTALS		198	285	483	74	95	169

Referring to the table shown on page 197 it should be noted that the figures shown are new cases in each of the years 1964/65/66. It will be seen that in 1966 there was a higher than usual number of new cases of glaucoma coming under treatment. The importance of careful follow up in these cases is shown by the fact that all of the glaucoma cases recommended for treatment, in fact received this on follow up. I know that in some cases the Health Visitor attached to a General Practitioner has played a part in this very important follow-up procedure.

Follow-up of Registered Blind and Partially Sighted Persons 1964-1966

A.

		Cause of Disability			
		Cataract	Glaucoma	Retrolental Fibroplasia	Others
December, 1964—					
(i) Treatment (Medical, surgical or optical) ...	...	26	2	1	12
ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	...	13	2	—	7
December, 1965—					
(i) Treatment (Medical, surgical or optical) ...	...	17	2	—	11
ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	...	8	2	—	8
December, 1966—					
(i) Treatment (Medical, surgical or optical) ...	...	12	11	—	6
ii) Numbers of cases at (i) above which on follow-up action have received treatment ...	...	10	11	—	4

B. Ophthalmia Neonatorum; there were no cases notified during the year.

Three quarters of those on the register are aged 65 and over.

Onset of blindness after retirement age is usually a gradual process and the emotional stress is likely to be less traumatic than during the active years of life. But it is nevertheless serious, creating more dependency, reducing the means of keeping in touch with the world, and adding greatly to the loneliness and limitations of old age. Many in this age group will be additionally handicapped by the loss of other faculties, particularly of hearing, on which they might otherwise increasingly depend, and some will deteriorate mentally. They must be helped to adjust to disability at a pace within their capacity. Much of the social rehabilitation which people newly-blinded in old age can achieve is gained through having personal help and understanding support. This calls for skill, particularly in the timing of introduction to Braille or Moon. Much distress can sometimes be caused by introducing these subjects before the blind person has fully accepted the reality of blindness. Attendance at craft classes and social clubs can play an important part in helping the elderly blind to maintain the will to live and to restore their sense of adequacy.

The main requirements for older people who have been blind all or most of their lives are additional care and the security of continuing so far as possible in a familiar routine. All the elderly blind may need special help in preparing for future dependency if admission to residential hostel or long term hospital care is likely to become necessary.

Of the two Home Teacher appointments in the Southern Area one has been vacant for sometime despite repeated advertisements. It was therefore recommended that, as some of the work could be under-taken by a Health Visitor or other social worker, the vacancy be filled for the time being by a temporary Welfare assistant.

A one day conference, arranged by the North Regional Association for the Blind was held in October at Manchester at which Miss Shuttleworth, Home Teacher of the Blind attended

The morning address on the incidence and causes of blindness was given by Mr. Michael Britten, Consultant Ophthalmologist at Stockport and in the afternoon the subject of the care of the elderly blind was covered by Dr. C. H. T. Wade, the Deputy County Medical Officer, Lancashire County Council.

Workshops for the Blind

The re-organisation is now complete and the industrialisation of the workshops is continuing.

The firewood department closed at the end of March and the plant and machinery surplus to requirements were sold for £500. The foreman of the firewood department is at present undergoing a course of training at a Ministry of Labour training centre to adapt him for alternative employment in another department.

An electric rotary cutter has been installed in the bedding department, in addition to a cushion filling blower unit to increase the production of scatter cushions; the purchase of this equipment has again been grant aided by the Ministry of Labour.

Mr. R. Lewis, M.P., for Carlisle, visited the workshops in September and congratulated Mr. E. McMurdo, a blind foreman who has designed a basket for use in Post Office sorting rooms. A month later the Mayor and Mayoress paid a visit, which resulted in good publicity for the work carried out at the workshops.

Major Holt, the Manager, has sent in this report:—

“During 1966 the Workshops has steadily consolidated its position. The improvements in space, production and sales were largely due to the programme of re-organisation carried out during 1965. With the termination of firewood production and sales in March, 1966 more van space was available for other products and deliveries have been quicker.

“The production flow in relation to labour and machinery has generally met sales requirements with a minimum of finished stock holdings.

“The squeeze has had a slight effect on turn-over towards the latter part of the year but increased efforts to maintain existing sales outlets and to provide new ones have been satisfactory.

"In particular the Upholstery and Brush Departments have had an increasing volume of work. New products have included fur fabric cushions, a simple design of hassocks for Churches and a steel framed upholstered chair for use by the Education Department.

"We are exploring the possibility of Contact Work from Industries in the area especially in the assembly and packaging fields.

"Visits have been made to other Blind Workshops in the area to maintain good relations.

"We have had a number of visits from leading personalities of the Local Authority, Industry and other Organisations. We are grateful for the interest shown by parties and individuals.

"Efforts have been and are still made to introduce selected disabled persons into the Workshops to complement the work of the Blind.

"The phased programme of re-painting of the interior workrooms has reached its final stages and the re-decoration has improved the appearance of the Workshop immensely.

"The morale of the workers generally is high and they are kept fully aware of all activities. Some highlights of the factory welfare activities have been an excursion to Blackpool during the Summer and a Christmas Party.

"We are still concentrating on the production of brushes, baskets, divan beds, mattresses, cushions, pillows and upholstery.

"We continue to believe that full employment is the best type of welfare for both blind and disabled."

Deaf and Hard of Hearing

Services for the deaf and hard of hearing, both voluntary and statutory, have lagged behind those for people suffering from disabilities whose effects are more easily understood. As a consequence the needs of deaf people are still not widely known and many of those concerned with providing a service for them have difficulty in assessing its value.

In considering the needs of the deaf, it is necessary to distinguish between those born deaf (as well as those who lose their hearing before acquiring speech and language), and those who become profoundly deaf after gaining speech in the normal manner. All too often, the handicap of deafness is seen as a speech defect, whereas the real problem is one of language. The major handicap of the deaf is not their inability to speak but their lack of vocabulary. Speech is an ancillary problem and means little or nothing to the deaf child who has not learned to symbolise verbally. Language and speech are not synonymous. A deaf person with language but no speech can always communicate by the written word. A deaf individual with a little speech but an inadequate vocabulary has only limited communication by any method. It is essential that those working with the profoundly deaf are able to communicate with them. Communication can be acquired only by practical experience and constantly being in the company of the deaf, and there are no short cuts.

Turning to local activities, the Hard of Hearing Club at Wigton still operates and meets on the last Friday of each month. Dr. Rogers has given a talk (and further talks are planned) on the causes and some treatments of deafness in school children: with the assistance of Miss Cronie, this was followed with demonstrations of equipment used by the teachers of the deaf.

During 1966 Mr. A. B. Hayhurst resigned as Secretary of the Carlisle Diocesan Association for the Deaf on his appointment as Secretary of the British Deaf and Dumb Association. Mr. Hayhurst has now entered a wider even an international field of service for the Deaf; he leaves behind a very fine service indeed in Cumberland where he has shown great devotion over the years.

My thanks are due to Mr. M. Barber, the Organising Secretary for the Diocesan Association for the Deaf, who took over from Mr. Hayhurst in May and has sent in this comprehensive report:—

“The needs of the deaf to-day remain the same as last year, the year before, etc. There is very little change, if ever, and the Association maintains the service which it set out to do when it was first started. In spite of the prophecy of realism wiping away specialist services for the deaf, we find that the school leaver needs the centres provided just as much as the senior citizen. It is a very pleasant surprise to see a teenager engrossed in deep conversation with someone thirty, forty, or fifty years older and both of them enjoying each other's company. The centres provided for the deaf at Carlisle, Barrow, and the Princess Street Community Centre at Workington are attended very well, and for the use of the latter we are very grateful.

School Attenders

“Every effort is made to see that the children are visited during the holiday periods. This visiting has a great bearing upon the future, as the Association accepts the responsibility of trying to place deaf school leavers in employment, it is essential to gain the confidence of the child, to let them get to know you, this leads to a greater understanding of the child and its capabilities. This visiting also assists the parents in knowing where help and advice can be obtained and that there is someone with whom they can confide, and perhaps share their anxieties.

Social Welfare

“Visitation of the deaf has been kept up throughout the year. Visits are paid them at home and at work, in hospitals and in homes. Anyone in hospital has been visited at least twice a week, more if possible. A deaf person in a hospital ward is really isolated and sometimes has no idea what is the matter with him/herself. We are also in a position to interpret where required for the benefit of the hospital staff. Visiting at work is more import-

ant than it sounds, it is not just a matter of 'How do! are you well, goodbye'. A deaf person thinks a great deal of his employment and tends to talk about it far more than a hearing person. Thus when he attends one of the Missions he likes to be able to discuss his job with the Missioner; if the latter has no idea what is involved the deaf person feels rather frustrated. This visiting can also help iron out any differences of opinion between employer and employee.

"Visiting the homes of the deaf brings to light many of the problems which the families may have, over a cup of tea many of the troubles come pouring out and it is here the greater part of our work can be done. An understanding of the language and the mind of the deaf is essential to understand the varied and complex problems they have. Many visits are paid during the evening when husband and wife will be at home together, and what is happening in the social world can be discussed and explained.

Employment

"This has been very good over the area; only one persons lost his job with the introduction of the Selective Employment Tax, and he was soon found another job in which he was financially better off. This man plus two further people who had been out of employment for a long period were found work.

Religious Matters

"Church Services are carried on as before. The Community Centre at Workington is used and is well attended, as is also the case with Barrow and Carlisle Centres. The deaf themselves take an active part in these Services.

Social Life

"The centres are open various evenings every week. Bingo, whist, film shows, talks, visits and outings are all organised and well attended. The older deaf have attended Rallies and Summer Schools, whilst the younger element prefer climbing, fishing, walk-

ng, pottery, painting, underwater swimming, etc. Quite a number of the deaf have become car owner/drivers, and have joined the British Deaf Drivers Association. We are hoping this year to start playing Badminton.

General.

“The Association has helped out in numerous other facets of life-interpretation at Weddings, Funerals, Driving Tests, Police Courts etc. Activities for the Deaf increase every year, and every effort is made to ensure that the deaf in our area have every chance to join in them.

“The Association does feel concern for the Deaf School Leaver of the near future. The so called ‘Safe Trades’—cobbling, french polishing, tailoring, joinery etc. are being killed with the advent of plastics, adhesives, mechanisation, and production line techniques. The employer of to-day requires an apprentice to have a G.C.E. and attend day-release and night school. Most deaf children leave school without a certificate of any kind and it is very difficult for them to attend any further educational classes where the teacher is not equipped to deal with them, unless accompanied by a qualified interpreter.

“It would be of great benefit if some kind of regional training establishment could be set up in the North to educate and train deaf teenagers for employment in other trades, giving them an even greater chance to try and integrate into the hearing world.

“The Association is willing to help interpret at any courses should their help be needed.”

Voluntary Work for the Elderly

The liaison between the voluntary organisations and departmental staff continues—the voluntary personnel make a splendid contribution to the welfare of the elderly.

Red Cross Liaison Officers have been appointed at eight Homes in the County, so that the British Red Cross Society have a channel of communication with the residential Homes.

The fine work of the Welfare Secretaries and Old People's Friends of the Women's Institutes in the County, continues to play a vital role in co-ordinating welfare work especially for the elderly in the community.

Meals on wheels have obviously become an integral part of the welfare services. Primarily their object is to help keep old people at home. This purpose is accomplished not only through the nutritional value of the meals themselves, but also by the regular cheerful and observant visiting of those who deliver them.

The meals on wheels service has continued to expand but the financial considerations at present may mean a slowing down of this progress.

Since the inception of this service which is admirably carried out by the W.R.V.S. the rise in the number of meals provided has been most remarkable as is illustrated in the following statement:—

1959/60	...	...	...	360
1960/61	...	...	...	1,814
1961/62	...	...	...	5,396
1962/63	...	...	...	8,368
1963/64	...	...	...	17,684
1964/65	...	...	...	27,814
1965/66	...	...	...	39,113

Meals are only served to the elderly on proved need and the recipients are most appreciative of what is being done to help them.

Details of new services provided during the years are detailed in the following report from the W.R.V.S. County Office:—

Generally speaking expansion of both Meals on Wheels and Luncheon Clubs has continued. One or two services have dropped owing to deaths and admissions to hospitals or Old Peoples Homes. The larger rounds always have a waiting list and can replace a recipient who drops out, but on some of the smaller rounds there are no waiting cases and these rounds must drop a little until further recommendations are received. We have held back a little on adding to rounds owing to the financial situation. New Meals services have been started as follows:—

Flimby—The service is organised by Maryport W.R.V.S. and meals are purchased from Long and Small Cafe, as Parkside Home is being used to capacity by the Maryport Town Service.

Blackford and Cargo District—This is a scattered round and meals are purchased from Park House Hotel, Kingstown.

Brampton—The meals are supplied by Moot Lodge Home and 24 recipients live in and around Brampton.

Nenthead—Alston organised this service and meals are taken round by members of the Old Peoples Welfare and their friends. The meal is purchased from the Crown Hotel, Nenthead, as Grisedale Croft is already supplying Alston Town meals. Also owing to weather conditions during the winter it might not be possible to get from Alston to Nenthead to deliver meals—even if the Home were not fully committed.

Egremont—A new Luncheon Club has been started at the Town Hall. The ground floor of these premises is rented by the County Council and handed over to W.R.V.S. to be used for the good of the community. The old people have the use of a very comfortable sitting room on Mondays and Wednesdays and the kitchen is used as a dining room. Monday's meals are purchased from Kangol Wear canteen, and Wednesday's are cooked by the Domestic Science class at Wyndham School. The girls order the food, prepare and cook it, and carry it over to the Luncheon Club where they help to serve. During

holidays W.R.V.S. members cook the meals on the premises. As well as the Luncheon Club the ground floor premises are used for the sale of Welfare Foods and a Play Centre for children. One of the W.R.V.S. members has offered to shampoo and set the hair of the women members of the Luncheon Club.

The van purchased with Cumberland County Council grant is being used to capacity in Ennerdale Rural District; this Centre delivers the largest number of meals from one canteen in the County. Five rounds are operated and meals are drawn from Hensingham School meals kitchen, and Whitehaven Geriatric Hospital. We cannot speak too highly of the help received from the Hensingham School meals kitchen, and the meals are excellent.

Workington, Maryport and Cockermouth had vans given for the conveyance of meals, and it is becoming evident that in due course the question of the transport of meals will have to be seriously considered.

In the meantime our members and helpers are doing excellent work and can expand the service still further, though this must depend on the money which can be made available by the County Council.

The Good Neighbour Scheme is small but obviously important, and arrangements were made for seven old people to be supplied with 677 meals.

We have been asked to start two or three new Meals on Wheels Schemes, but these are being held up at the moment until we hear how much money will be available.

Our thanks are due to the suppliers of meals—we continue to receive the willing help and co-operation from the County Council Old People's Homes, and most of the caterers from whom meals are purchased seem to be genuinely interested in providing a suitable meal.

Nursing and Medical Staff are anxious to ensure that more old people should be supplied with meals, but their requests can only be met if the money is available, and the proposed service has been included in the financial estimates which are submitted to the County Council.

Mrs. Ellwood, Old People's Welfare Organiser, Cumberland Council of Social Service has also sent in a contribution regarding voluntary work:—

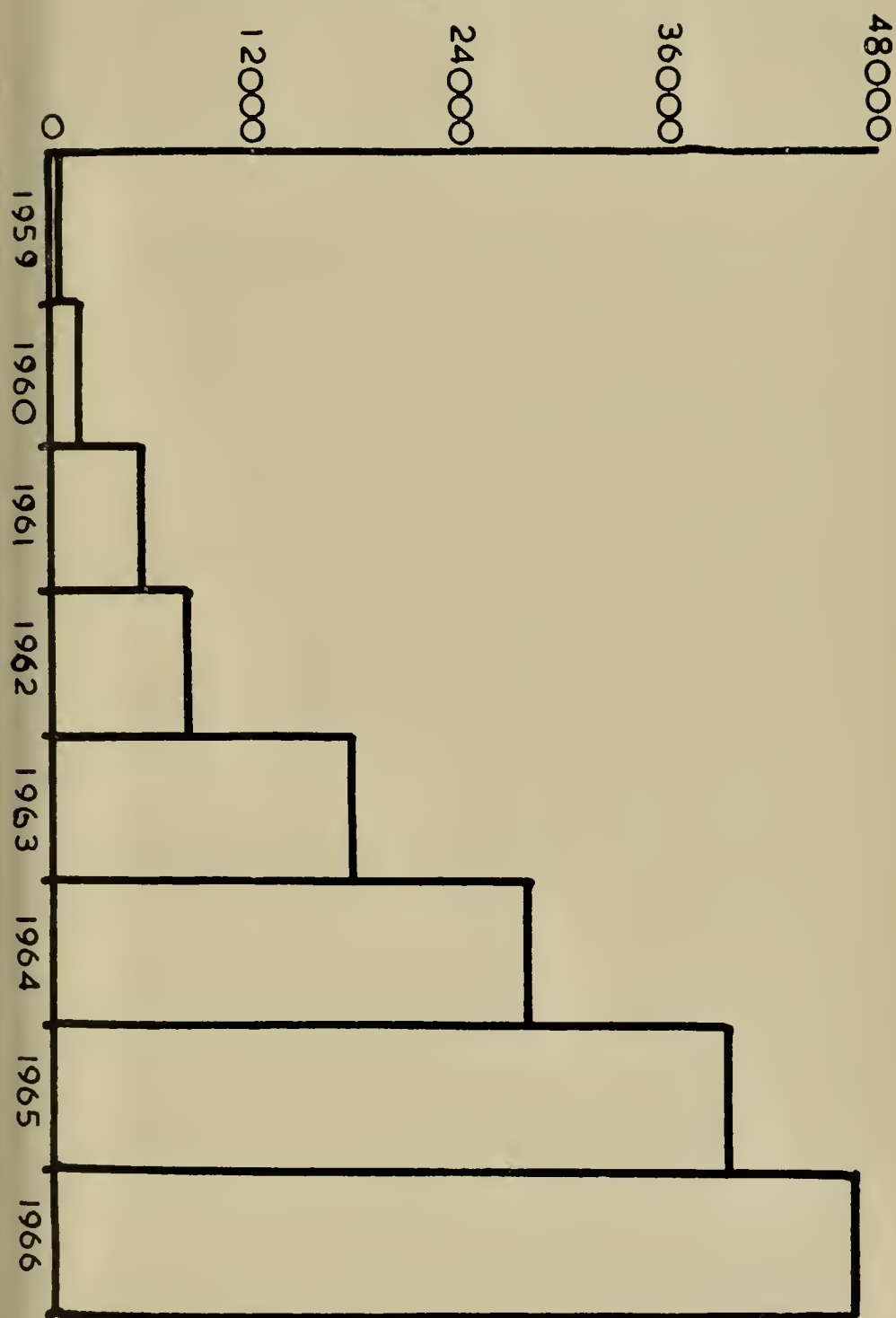
"I believe it fair to say that voluntary work has again 'stepped-up' during the year. Not only has the volume of work increased, it has expanded into new channels and found, as voluntary work always will, new avenues of service. Neither can it any longer be regarded as unreliable. A very great deal of consistent effort has been maintained, in addition to the finding of new volunteers to provide additional services. This in spite of the fact that many of these have only a very limited amount of free time, with responsibilities both to their home and their work.

"Most Homes throughout the County now have their groups of 'Friends' who are actively helping to provide extra comforts and amenities for the residents. This involves both time and money. Work with the physically handicapped has been new and rewarding, but has needed sustained effort and will continue to do so. The number of Village Clubs for the elderly is growing, and this rapid growth will involve more volunteers in running the Clubs and in some cases providing transport. Lunch clubs have increased, two of these being most efficiently staffed by schoolgirls who both cook and serve the meals. Indeed, the amount of voluntary effort contributed by young people is both very considerable and often original in conception. Volunteers have been helping to run craft classes for Over 60's, with visiting, and sometimes with daily care of elderly neighbours. That Training Conferences which provide information and advice have been so well attended indicates a sense of responsibility and desire on the part of all concerned to do their voluntary work well and efficiently."

The two luncheon clubs which started during the year are at Aspatria and Egremont. The girls in the domestic science classes at Beacon Hill and Wyndham Schools order the food, prepare and cook it, then take the meals to the luncheon club where they help to serve.

All in all the quality and quantity of voluntary services closely associated with the work of the Health and Welfare Department, is a magnificent tribute to community interest in the less privileged and less able members of society. The whole situation in respect of voluntary work is most encouraging, it points to the steady development of a truly participant society; a social situation in which statutory services can and do function with greatly enhanced efficiency. The combined voluntary and statutory effort for those in need accomplishes vastly more than either element of service could achieve alone.

NO. OF MEALS SERVED



MENTAL HEALTH



MENTAL HEALTH

The year under review can best be described as one of consolidation and continuing development of the community care services for the mentally disordered. This has been along policy lines laid down since the Mental Health Act 1959 directed attention more towards the promotion of mental health by the prevention of mental illness. The development of this concept has been more effective to the Health and Welfare Department as a result of the introduction of area administration. In delegating day to day administration and organisation to Area Medical Officers and their staffs, personal problems involving human relationships can be tackled more speedily and effectively at a local level. To complement this the amalgamation of the mental health and welfare functions both at field work and administrative level has considerably simplified the development of a team work approach to the social problems of the handicapped whether these be mental, physical or resulting from old age. The social workers are thus able to develop, in association with their colleagues in the nursing and other local authority services, a team work approach to the wide variety of medical/social problems which come their way. The very close links which have been forged with the general practitioner service by the attachment of local authority nursing staff to group practices, have undoubtedly resulted in greatly improved service to the patient. A somewhat similar, though perhaps more loose, arrangement between the family doctors and the social welfare officers is developing in an encouraging manner and is being welcomed not only by the general practitioners but also by the hospital and consultant services. All appreciate the value of this link between the three parts of the National Health Service for the total benefit of the patient. The table which follows give a précis of the statistical returns relating to the Mental Health Services which are required by the Ministry of Health at the end of each year and covers the period since the Mental Health Act 1959 came into operation.

	1961	1962	1963	1964	1965	1966
Case load at year end—						
Mentally ill and psychopathic ...	115	250	292	328	396	447
Subnormal and severely subnormal	351	359	391	437	449	511
Total ...	446	609	683	765	845	958
On training centre registers ...	71	86	95	119	135	162
Awaiting admission to training centres	42	46	42	45	39	33
In local health authority residential care	18	21	16	33	25	38
On hospital waiting lists (subnormals)—						
Urgent cases ...	—	1	1	4	1	—
Others ...	39	46	31	20	13	13
New cases referred during year—						
Mentally ill and psychopathic ...	194	235	211	230	223	202
Subnormal and Severely subnormal	35	71	42	86	62	70
Total ...	229	306	253	316	285	272

The total number of patients under local health authority care in their own homes has doubled within the past five years. Whilst there has been a gradual increase in the number of those in the subnormal category the significant increase has occurred amongst the mentally ill. The number of new cases referred each year has not shown much variation and the 1966 total of new cases (272) is marginally above the average for the past six years. More detailed analysis of the figures for new referrals of the mentally ill from hospitals following either in-patient or out-patient treatment, reveal a wide variation as between the two main sources of referral. From the psychiatric unit of the West Cumberland Hospital and its associated clinics there were 150 referrals during 1966, compared with only 7 during the year from Garlands Hospital and its associated clinics. These figures probably reflect the differing functions of these two forms of hospital provision. That at the West Cumberland Hospital is the provision of the future in the shape of a psychiatric unit within a district general hospital catering in the main for the active treatment of acute mental illnesses. Garlands Hospital on the other hand is characteristic of the older type of mental hospital housing a large proportion of chronic long-stay patients.

In earlier reports I have commented on the use of alternative methods of securing the compulsory admission to hospital of mentally disordered patients for a period of observation. Section 25 of the Mental Health Act 1959 laid down the normal procedure involving medical recommendations in each case not only by the usual medical attendant of the patient but also by a doctor having special experience in the diagnosis or treatment of mental disorder. In cases of urgent necessity the authority for compulsory admission can be taken under Section 29 on the basis of a single medical recommendation if the obtaining of the second medical recommendation required by Section 25 would involve an undesirable delay. In October 1966 the Ministry of Health found it necessary to draw attention to the high proportion of compulsory admissions to hospital for observation which had been effected during 1965 under the single doctor procedure of Section 29. In Cumberland between 1961 and 1966 it was found that 52.4% of primary admissions for observation under compulsory procedures (Section 25 and Section 29) were admitted under the single doctor procedure of Section 29. This proportion is not thought to be excessive, bearing in mind that the majority of the doctors who by their "special approval" are empowered to furnish the second medical recommendation required by Section 25 are consultant psychiatrists based on hospitals which have very wide catchment areas. A high proportion of these admitted under Section 29 very quickly have a second recommendation completed by a psychiatrist who has seen them in the recent past at an out-patient clinic.

It would of course be helpful if more general medical practitioners in this scattered rural area were approved for the provision of second recommendations but the total list was supplemented by only one such doctor during 1966.

Towards the end of the year a procedure was approved to overcome certain legal difficulties which have occasionally been experienced in connection with admission of patients who are both mentally ill and in urgent need of general medical care, such as

1. cases of self poisoning in which the patient admits to having ingested drugs or poisonous substances and then refuses to go to hospital.
2. self-inflicted injuries of a serious nature accompanied by similar refusal
3. patients who develop acute potentially fatal medical or surgical conditions which would be amenable to hospital treatment yet who refuse such a treatment by reason of impaired judgement due to associated mental illness.

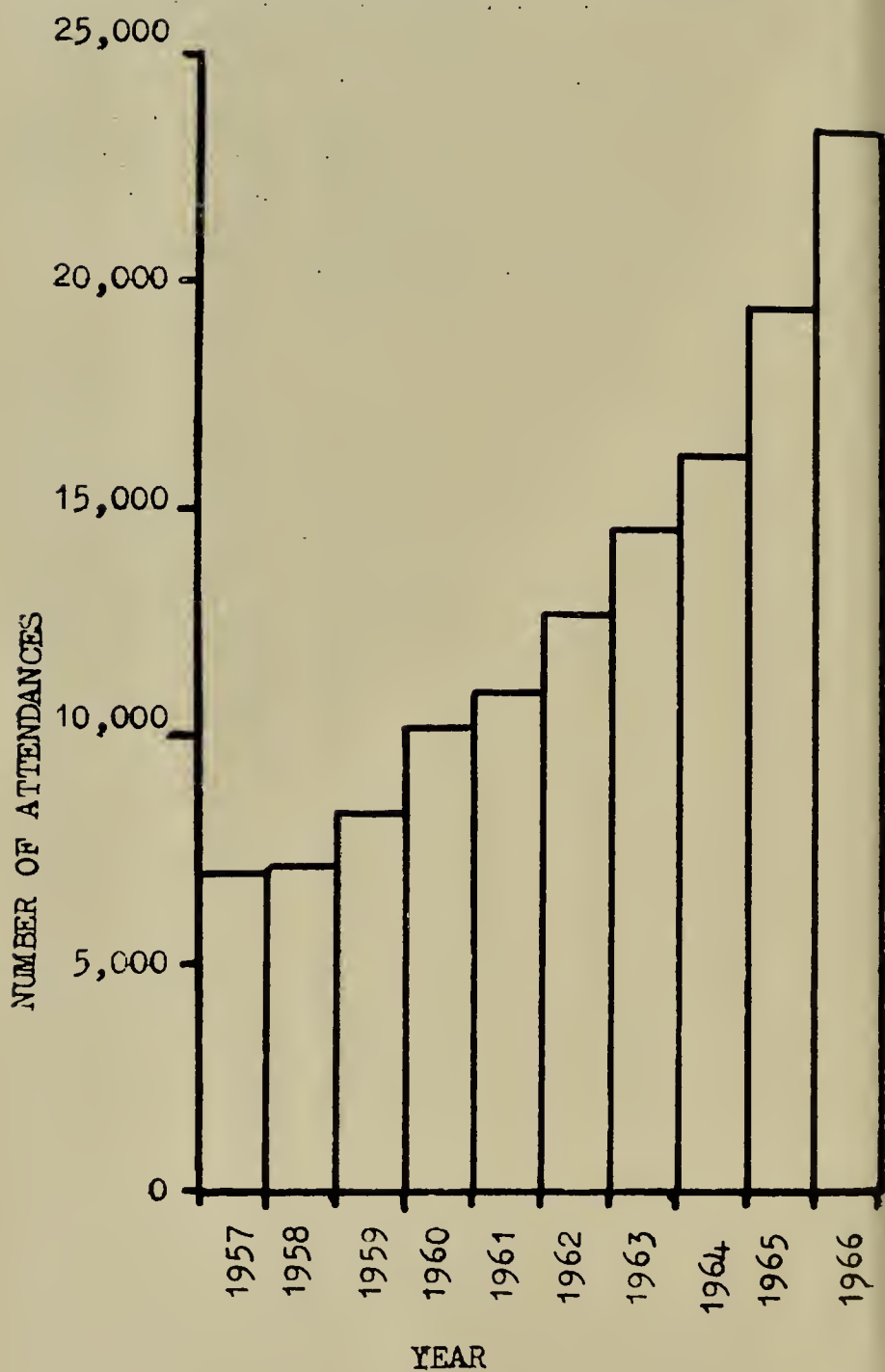
In the past the psychiatrists in the northern part of the County have had to advise that the patient be sent to Garlands Hospital under Section 25 or Section 29 of the Mental Health Act and following the reception of the documents there, the patient was then transferred for treatment to the Cumberland Infirmary. The necessary administrative machinery has now been set up at this latter hospital whereby certain members of the medical and nursing staffs are authorised to receive all documents required under the Mental Health Act.

TRAINING CENTRES

With the opening of the Hensingham Junior Training Centre on the 20th April, 1966, a milestone in the authority's training facilities for the subnormal was reached. For the first time in Cumberland all the buildings used for this purpose are relatively new and purpose designed. Before considering these developments in detail the rate of development of this aspect of care for the subnormal within the community during the past ten years is illustrated in the following graph and table.

1

TRAINING CENTRE ATTENDANCES



TRAINING CENTRES—NUMBERS ON REGISTERS

Year		Under 16 yrs.	16 and over	Total
1957	...	37	9	46
1958	...	32	14	46
1959	...	43	17	60
1960	...	49	21	70
1961	...	51	20	71
1962	...	61	25	86
1963	...	59	36	95
1964	...	73	44	119
1965	...	77	58	135
1966	...	99	63	162

It will be noted that the total attendances during 1966 showed an increase of 3,858 (nearly 20%) over the corresponding figure for the previous year.

Junior Training Centres

The high priority accorded these centres in Cumberland is reflected in the fact that by the end of 1966 the provision for training junior subnormals was at the rate of 0.52 per thousand of the population whereas the national average is not expected to reach a similar figure until 1971. The total number of places available reached 120 (including special care facilities) with the opening of the Hensingham Junior Training Centre. This new Centre replaced the former adapted building at Flatt Walks, Whitehaven, which had been in use since 1954. The Centre, which represents up to date thought in design, is a single storied detached building in extensive grounds with provision for separate nursery, junior, intermediate and senior groups and incorporating a unit for those children who because of severe or multiple disabilities require "special care". It also contains separate facilities for those older children at the stage of transition from junior to adult training.

The smaller unit at Wigton continues to make satisfactory progress. This centre is closely associated with the junior hostel for subnormals at Orton Park, which provides boarding facilities (excluding week-ends and training centre holiday periods) for those children who live in the more remote parts of the county area from which daily travel to a training centre would be impossible. The extension of this centre by the provision of an extra classroom has been well justified in that it is now possible to regroup the children into four more effective teaching units. Some uneasiness was felt towards the end of the year about the introduction of a small number of very severely handicapped children into this centre. This was thought to be having an undesirable effect on the efficiency of the total training unit and so alternative arrangements were made.

Special Care Units

The Ministry of Health has encouraged local authorities to develop some form of provision (usually associated with training centres) for those children "unsuitable for education at school" who are unable to profit from the type of training available in the junior training centre. This small number of children suffers from very severe mental and physical disabilities. The nature and severity of their handicaps placed an almost intolerable strain on the parents which could only be relieved by arranging short term hospital care when this was necessary and possible. In general the parents of such children would not consider long term hospital care even if this were available and offered to them. With this obvious need for parental relief in mind, a few parents agreed to their children to be taken to the former Whitehaven Junior Training Centre for two or three half days each week. The value of this simple provision was quickly demonstrated. The children concerned although so helpless often showed obvious enjoyment in their association with other children which was in turn reflected in the ability of the mother more easily to tolerate the conditions which the child's disabilities imposed on the family unit.

There was a small demand for this service in respect of children within a reasonable travelling distance of the Wigton Centre and accordingly the unit was opened for one full day each week, in an annexe to the room which is used by the nursery group. All three children admitted were severely disabled both physically and mentally, none of them could stand unaided, all were doubly incontinent and it was necessary to transport them to and from the centre by ambulance. It quickly became evident that the attention they required was so great as to be beyond the capacity of the staff without serious detriment to the rest of the children. Although their ages ranged from six to eleven years they needed feeding and changing as a small baby would and voluntary help which was enlisted could not be maintained. The volunteers found themselves ill-equipped for their difficult task. For these reasons, coupled with the fact that the presence of the special care group in the same room as a teaching group was found to be too distracting to the trainable children, it was decided to withdraw

these facilities from the Wigton centre and to look into the possibility of opening an alternative special care unit at the Orton Park hostel. This was accomplished in September and facilities are now available for up to six children on the basis of one day each week with nursing supervision.

The special care unit at Hensingham Junior Training Centre became available on a full time basis with the opening of a new centre and there are at present nineteen children attending although the maximum attendance at any one time is restricted to ten. The frequency of attendance of individual children is manipulated to ensure that every child thought suitable for this form of help receives it in some measure. The factors governing the pattern of attendance are need and geography. Here again it quickly became evident that a single member of staff although a well qualified and experienced nurse could not manage without assistance from other members of the staff whenever a child needed toileting or cleaning after soiling, and regularly at dinner times to help with the slow feeding of the severely handicapped group. Nursing techniques are much more appropriate to the needs of these children than is the educational approach which is so necessary in the training of the other children at the centre. A second nurse was therefore appointed to this unit which is now functioning well.

Although the social benefits which accrue to families which contain a very severely handicapped child are enormous, the need for nursing care as distinct from training leads one to think that this service might be provided in day hospitals rather than in association with the local authorities' training centres. For the majority of the children at present attending our special care units there is virtually no prospect of their being able to take part in the normal training curriculum of the junior centre. I fear that these special care units will tend to become over loaded with very seriously disabled children to the possible exclusion of those who can be regarded as ultimately trainable within the junior centre, but whose physical handicaps or behaviour difficulties make such a temporary provision necessary. I am indebted to the supervisor (Miss Love) and her staff for their strenuous efforts in launching this new enterprise and would like to quote extracts from reports received from Miss Love and her assistant, Mrs. Martin.

Miss Love writes:—

“How the children benefit from coming to the Centre is difficult to assess but in many cases improvements can be seen. This is a very slow process but with patience and understanding much can be achieved. Although a child may not be able to progress through to the junior centre there is ample evidence of a happier and fuller life than would have been achieved without the help of the special care unit. The parents obviously benefit a great deal from the child’s attendance at the unit. They are very grateful for this help and are always delighted at any progress which their child makes”.

Mrs. Martin writes:—

“Feeding the children, although a very slow business, now presents few problems. The school meals which are normally supplied to the centre are often unsuitable for children who have difficulty in masticating or swallowing. This has been overcome with the help of the school meals service who each day supply a special menu for the children in the unit which enables some of the less handicapped to feed themselves. In other cases the parents are most co-operative and send strained baby foods and drinks.

“Quite a few of these children spend the greater part of the day on the floor and it has been suggested that electric underfloor heating would be suitable for this type of unit. I find our present arrangement quite satisfactory.

“Equipment and toys of a suitable type are a problem. Thin rubber mattresses on the floor for our more immobile children have been tried but this can prove hazardous to other children who are stumbling around. Walking aids are encouraged and are popular. Generally speaking the parents are most grateful for the facilities provided, quite a few have commented on a marked improvement in their children since attending the unit—in their speech, toilet training and walking.

“Mrs. Bowen and I are very happy in our work and find it interesting, rewarding, and stimulating”.

Adult Training Centre

Cumberland's first Training Centre for adult subnormals came into use early in 1965 as the first phase of a development providing training facilities for 50. Later extension in the second phase was envisaged to increase the total accommodation to 80 places. Dining, kitchen and toilet accommodation in the original building were designed to cater for the total projected development in the confident expectation that further workshop places would be forthcoming within two or three years. It is therefore most disappointing to learn from the Ministry that loan sanction for the proposed extension is not likely to be forthcoming before 1968/69, although it was included in the Council's development programme for 1966/67. There are now 60 trainees on the register and at the time of writing 3 are awaiting admission, quite apart from the fact that there are 10 subnormals at present attending junior centres who will be ready for transfer to adult training before the extension becomes available. This Centre is now overcrowded particularly on the male side and attendances for 1966 show a 25% increase over 1965. At 0.22 per thousand population Cumberland's present provision for training adult subnormals is about 30% below the national average and the further postponement of the building programme is having a serious effect on the service.

To meet the need in the Northern and Eastern part of the county a second adult centre for 50 trainees is planned for 1969/70 and this has been provisionally included in the approved list. Only when the third adult centre materialises at Maryport (again for 50 places and scheduled for 1970/71) will the authority have brought its total provision up to the national average.

It is difficult to make accurate forecasts of the number of adult subnormals requiring training in the years ahead. The situation is affected by the voluntary nature of attendance at a centre; the general level of employment in the area (an unfavourable factor in Cumberland) and the shrinkage of opportunity in a mechanised agricultural industry.

The incentive payments scheme which came into operation towards the end of 1965 whereby all trainees receive a payment

of 2/- per day was reviewed in March when it was decided to introduce a scheme of additional payments of 6d. or 1/- a day at the discretion of the supervisor on assessment of effort, diligence, social adaptation and general conduct. The aim of training in adult centres is to continue the training and social education of the subnormal into the adult phase, the emphasis changing towards a workshop rather than a school environment. The training is directed towards social maturation by teaching a more adult approach to human relationships, by encouraging independence and by teaching adult disciplines in a workshop environment. The trainee learns to accept instructions, to conform to adult standards of behaviour, to increase his span of concentration on the particular job on hand and to work as a member of the team. As a by-product of these training activities under workshop conditions, saleable goods are produced which in the year under review realised £2,104. 18s. 3d.

HOSTEL ACCOMMODATION

(a) For Subnormals

The hostel at Orton Park which was opened in 1959 so that children from the more remote areas of the county could receive training at a junior centre was never fully occupied during 1966. Accommodation is available for 22 children but it has been fully occupied only on rare occasions since it was opened. The maximum number of children in residence during 1966 was 17 and the average daily occupancy was 14.5

It can, I feel, be said that this unit has met a type of need which arises only in scattered rural areas. Orton Park came into use at very little cost to the authority and has proved adequate to meet all demands upon it. Future policy, which has been accepted by the Council, will be towards its replacement in the 1971/76 period by small "family-unit" type homes.

(b) For the Mentally Ill

The first hostel for the support of the mentally ill in the community was opened on 8th February, 1966 after a series of frustrating delays. Called "Fairview" it is located at Bransty Road, Whitehaven, and provides accommodation for 17 residents all in single rooms. The hostel is so designed that the building can be extended if necessary to accommodate 30 residents without alteration to the kitchen, dining room or lounges. I think it is worthwhile to review the background of this development of the community care services.

Consideration of the provision of this type of accommodation began as long ago as July, 1961, but it was not until April, 1962 that a site was acquired which seemed to satisfy all the requirements, viz. not too close to the psychiatric unit at the West Cumberland Hospital within easy reach of public transport services both by train and bus; close to a shopping centre and all the other social amenities; and where local opposition to the establishment of a unit of this type was not likely to be particularly strong. The site chosen is located in a relatively densely populated area and a district which offers the widest range of job opportunity.

Then followed much consultation with my medical colleagues in the psychiatric and general practitioner services, with social workers, with voluntary agencies—indeed with anyone whose experience and opinions might contribute to the planning of this project. Because these hostels were (and still are) comparatively new there was little experience from which to draw. Help was also received from the officers of the Ministry of Health's regional office and as a result of visits to other similar hostels. It was ultimately decided to restrict admissions to the hostel to those who had reasonable prospects of rehabilitation to full community life within a period of 6 to 9 months. Referrals to the hostel would be accepted from the hospitals, from general practitioners and from social workers but preferably with the support of the senior consultant psychiatrist in West Cumberland (Dr. Drummond); and that, after consultation with the Warden, I would approve admission. It was also agreed that the Senior Social Welfare Officer in the southern area (based on Whitehaven) would lend every support to the warden in the social rehabilitation of the residents. The staff complement consists of a full-time warden (Mrs. Cowham) who occupies a flat on the premises, a full-time non-resident assistant warden and, on the domestic side, a full-time cook and two part-time domestics. Mrs. Cowham is a trained and experienced mental nurse.

Originally planned for 30, the number of places in the hostel was subsequently reduced to 17 while considerable uncertainty remained as to the extent of likely need. The building was planned so that extension would be possible if later indicated. Very little helpful experience from other authorities was available for guidance.

As was expected, Cumberland's hostel got off to a slow start. I would like to place on record my deep appreciation of the very commendable way in which the Warden (Mrs. Cowham) has tackled a very difficult job and wish to thank her for the following clear and concise report on the first year's operations at Fairview:—

"Prior to the opening of Fairview, I visited three other Half-Way Hostels in other parts of England. Broadly their purpose seemed split into two main functions.

- (1) To provide accommodation in an unstructured environment for those who had suffered mental illness and were ready for rehabilitation and resettlement.
- (2) To provide temporary accommodation at times of social crisis for those known to the Local Authority who had suffered mental illness in the past.

The success in meeting these functions seemed directly related to selection procedures, type of illness in persons admitted, local environment and supporting medical and social services.

“Fairview took these functions as its aims initially and its ways of fulfilling them in its own setting seem to have evolved in three main phases so far.

First Phase: Duration, five months approximately. Fairview opened in February, 1966, with a complement of 5 residents—one woman and four men. Age range was 25-45 years. None were of particularly high intelligence, most were rather flat and inactive. Some were still acutely ill and all had considerable hospital experience. Only one seemed really aware of the hostel's purpose. Most seemed to view the hostel as a pleasant alternative to hospital.

“The level of constructive activity was low. Pastimes (television, cards, etc.) soon palled and testing behaviour increased, ranging from subtle attention seeking to rebelliousness and open violence.

“Three of the first five residents had to be returned to hospital. However, total admissions during this phase reached fourteen.

“Before the end of the first phase it was felt that over-optimistic selection of residents was unhelpful and unfair both to the prospective residents as well as to those already in residence.

"It was decided that nominees for the hostel would in future be seen by the Consultant Psychiatrist, the Warden and the Senior Social Welfare Officer of the area, and that a visit to the hostel would be arranged before admission where possible. The idea was to make sure the prospective resident was involved in the hostel's purpose and agreed with it in relation to his or her needs.

Second Phase: three months—approximately. Notably the eight residents admitted during this phase were of an older average age and also of a generally higher degree of intellect. All had long histories (up to 20 years) of mental illness.

"These residents were vital to the hostel in providing a pattern and a period of relative stability while the experiences of the first phase were digested.

"Testing behaviour was still much in evidence amongst residents but the difference in its quality in this phase was that it was directed mainly towards testing new found freedom allowed by the hostel's environment and atmosphere, in the first cautious steps back into patterns of normal living and full association with the community.

"The increasing tempo of the hostel can perhaps be best illustrated by mentioning the progress of two residents after coming to the hostel: (A) This resident had been ill for about ten years and in hospital continuously for eight years. When she came to Fairview she was timid, apprehensive, lacking confidence and unable to go onto the street unaccompanied. To her consternation she was found a job within a week and to her surprise she was able to cope with it. She now moves in the community at will.

"(B) Ill for at least fifteen years, this resident spent most of the last ten years shunning society, in bed at his home. Within a short time of arriving at the hostel there was a marked change in appearance and outlook and, after some months, attendance at a course of rehabilitation organised by the Ministry of Labour was arranged and it is hoped that employment will shortly be found for him.

Third Phase: three months approximately. Long histories of mental illness were common to all of the nine new residents admitted during this phase.

“However, with an increasing total of residents in the hostel, the progressive and outgoing atmosphere was fostered and maintained.

“With the increase in the number of residents, minor frictions increased and there was a great demand on the staff for support by residents in solving these difficulties. Apart from the frequent opportunities for informal and, if necessary, private discussions, regular fortnightly meetings of the Warden, her assistant and all residents were started, to discuss conduct in the hostel and the operation of it. So far these meetings have been used as a forum for complaints between residents; it is hoped that these discussions will extend to cover experience of the problems of rehabilitation and resettlement.

Contact with the Community: At the opening of Fairview there was still suspicion and resentment towards the hostel in the neighbourhood. Local children, and even prospective employers, referred to Fairview as the “Nut House”.

“With few residents initially and generally of a low level of activity, the temptation to organise continuous activity in the hostel was strong. This was resisted and residents were encouraged to get out and about.

“However, to provide openings for meeting local people a club was started with monthly meetings. It is run by a committee composed equally of hostel residents and local people. Activities in Fairview have included parties, games evenings, film shows, coffee evenings, a trip to Morecambe Illuminations for residents and relatives and local friends. It is hoped to widen this list to include evenings at a theatre and occasionally dining out.

“As a result of past activities resident have made friends around the hostel and often pay visits to them in their houses.

Employment: Fairview's most serious problem and continuing difficulty is in finding employment for male residents. This is a reflection of the local situation of high unemployment in West Cumberland, the lack of variety of local industry, the need to select and match residents' abilities with employers' needs and a reluctance by the Ministry of Labour to put forward our residents to employers locally.

"Fourteen out of twenty-nine residents have been found employment.

Selection: Selection was initially over-optimistic and involved residents who were acutely ill and/or showing severe behaviour disturbance. There was and is a proportion of subnormal residents whom it is found very difficult to integrate into the activity of the hostel, and who create problems out of proportion to their numbers.

"So far, the most encouraging results have been with residents whose illness is of a psychotic nature and long standing.

Summary: The hostel has gained some momentum in its first year of operation and seems to be partially fulfilling its initial functions.

Advances for the future: It is hoped the general employment situation will improve and that the Ministry of Labour will find themselves able to give increasing help.

"It is hoped that Fairview will help its residents to mature increasingly into greater and greater independence via group meetings and activities and involvement in their own individual and corporate experiences, problems and their solutions.

"Materially the major challenge in the fourth and succeeding phase is the finding of accommodation for those residents who have no relatives, so that they may claim their independence, whether in lodgings, in some form of 'foster' situation or in dwellings allocated by the local housing authorities."

The following tables give statistical data for the period from the hostel's opening on the 8th February, 1966, until the end of the year:—

Admissions (including 2 re-admissions)

	Male	Female	Total
From Garlands Hospital ...	7	8	15
From West Cumberland Hospital	2	—	2
From Home	4	8	12
	13	16	29

	Male	Female	Total	Average stay (days)
Returned to hospital ...	4	2	6	36
To residential employment	2	2	4	39
To home or lodgings ...	2	3	5	57
	8	7	15	45

Remaining in residence at 31/12/66	5	9	14
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	Admitted	Discharged	In residences at year end
Chronic schizophrenia ...	17	7	10
Schizophrenia with person- ality disorder	2	2	—
Subnormality	6	3	3
Psychopathy	2	2	—
Epilepsy	2	1	1
	29	15	14

I think it should be noted that of the 14 residents placed in work all were found jobs after admission to the hostel, in 11 cases by the warden, in 2 by the Ministry of Labour and in one by a social welfare officer. This was achieved in these cases in an average period of less than 20 days from admission.

The team spirit which has developed has contributed greatly to the success so far. This refers both to the medical and social worker team and to the very creditable involvement of the local community in the purposes and activities of the hostel.

STAFF RECRUITMENT and TRAINING

(a) Social Workers

Although the number of approved courses for the training of social workers over the country has increased from 4 in 1961 to 27 at the end of 1966, the output of trained workers is still small compared with the likely demands of local authorities. One problem here is the difficulty in allocating the time of hard pressed trained workers to assist in the training of others. There is also a need to attract more actual or potential university graduates into the service.

Cumberland having early commenced subsidised training for social workers is in a better position than many authorities. During 1966 two social welfare officers and a trainee commenced two year courses leading to the certificate in social work and one of the senior social welfare officers was seconded to a one year university course to complete professional social work training. It was encouraging that all Cumberland's nominees have been offered places on courses when it is considered that there are three times as many applicants as there are places available. Cumberland's present programme of training should provide 9 out of 16 staff trained by 1968, and 13 out of 17 trained by 1970.

At the time of writing this report the conclusions of the Secbohm Committee which is reviewing local authority social services in relation to the family are awaited. These may well determine the pattern of social work in local authorities for a long time ahead.

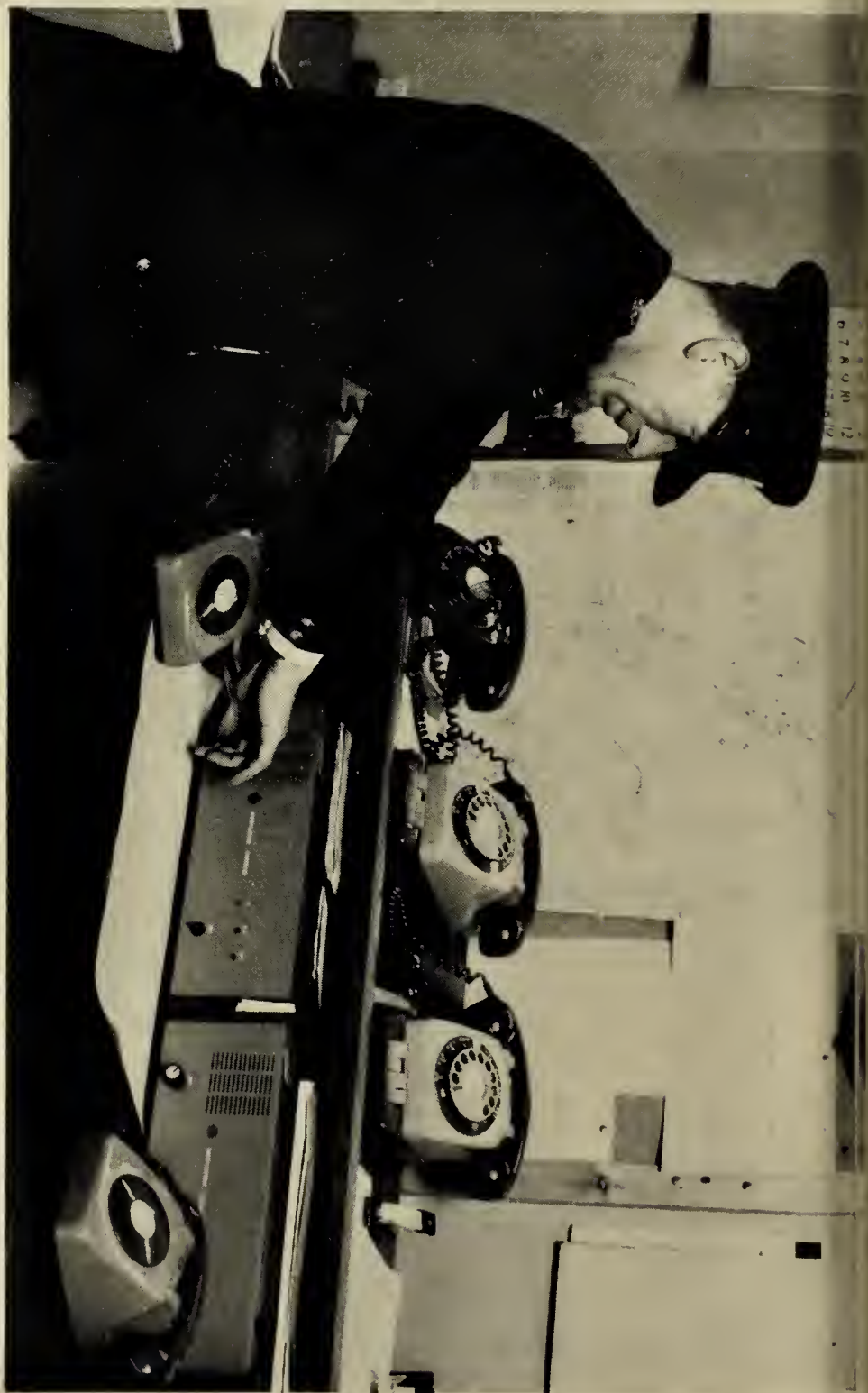
(b) Training Centres

The decision has already been mentioned to recruit nurses in special care units. This so far has not presented difficulty. The second of the training centre trainees commenced a 2 year course in September, the first will return qualified in September 1967, and the second the following year. This scheme will to some extent meet the need for trained staff in junior centres. I am glad that it has also been possible during the year to offer one of the slightly older more senior assistant supervisors a short one year course of training.

AMBULANCE AND SITTING CASE CAR SERVICE

Section 27 of the National Health Service Act, 1946

“It shall be the duty of every local health authority to make provision for securing that ambulances and other means of transport are available, where necessary, for the conveyance of persons suffering from illness or expectant or nursing mothers from places in their area to places in or outside their area.”



CONTROL ROOM, DISTINGTON AMBULANCE STATION

COUNTY AMBULANCE SERVICE

Mr. M. F. Smith, F.I.A.O., County Ambulance Officer, submits the following report:—

Introduction

This year has really been one of consolidation following the opening of the new stations at Distington and Wigton in 1965 and the emphasis has been on training. As a result there is now a close-working relationship between the hospital staffs and ambulance drivers, which in turn was made possible by the provision of radio-telephone facilities at the Cumberland Infirmary, Carlisle. This success underlines the need for similar facilities at the West Cumberland Hospital.

The work of the service continues to increase and I think it must be accepted that if increased and improved medical and transport facilities become available more use is made of them by the general public as is indicated on the accompanying graph.

Owing to the introduction of the forty hour week an increase of three staff was necessary, bringing the total staff to 66. The increase was kept as low as this, in spite of the continuing pressure of demand on the service, by more efficient deployment of vehicles and men made possible by the growing experience in the use of radio control and by asking the Hospital Car Service drivers to undertake more work.

There are now only two stations in the directly provided service still housed in unsatisfactory premises. As the standard of efficiency at any station is closely related to working conditions, credit is due to the staff at the Bush Brow Station, Carlisle, and at Millom, whose enthusiasm for their work remains undiminished.

Operational Developments

Difficulties in connection with requests for ambulance transport have unfortunately not yet been eliminated—and probably never will be completely—but determined efforts are being made

by both the hospital authorities and ourselves to reduce them to a minimum and to reconcile the needs of both services. These difficulties fall mainly into two categories: where ambulance transport is ordered but the patient finds alternative means of transport to hospital, and problems arising out of either cancellations or alteration of patients' appointment times.

As will be seen from the accompanying statistics the work of the service continues to increase; mileage by 8% and patients by approximately 3%. These percentage differences are accounted for by the location of the new District General Hospital and consequent hospital re-organisation in West Cumberland resulting in additional mileage for vehicles from Maryport. It necessitated an additional vehicle at Maryport. The reduction of public transport in the Millom and Keswick areas, as well as from Silloth to Carlisle is also a contributory factor. The continuing increase in the number of journeys to treatment centres in the Newcastle area has had a marked effect on the mileage as many of the journeys are from West Cumberland, which means a round trip of at least 200 miles. Many of these patients are taken to the Ministry of Health Limb Fitting Centre and efforts are now being made, firstly in the patient's own interests, and secondly for economic reasons, to try to establish (say once a month) a limb fitting clinic in Cumberland.

A further possible demand on the Ambulance Service for the future is association with developments in general practice and the increasing interest in Health Centre development. Much of the time of many doctors, especially in rural areas, is occupied in visiting patients, many of whom could contact him at the surgery or health centre given transport from home. It is not possible to see clearly at present how the Ambulance Service might figure in such a development but I am sure much thought will be given to this subject in the near future.

A total of 588 road accidents were dealt with during the year, with road junctions appearing to present a particular hazard.

Consideration was given to extending the directly provided service to include Keswick because, although it occupies a geographically central position, its operational isolation presents

special difficulties. Practically all cases requiring specialist treatment in the Keswick area are conveyed to either the Carlisle or West Cumberland Hospitals.

After considering comparative costs and the advantages to be gained by a directly operated service it was decided that the Keswick service, at present on a contractual basis, should be reorganised and brought within the general scheme. Unfortunately, the general financial situation has meant the postponement of the scheme.

There was some difficulty about the procedure which should be adopted by ambulance crews in the disposal of accident cases, particularly those cases occurring in or near Alston, Keswick and Penrith, where minor accident facilities are available. It was decided, after discussion with the Local Medical Committee, to instruct ambulance crews that in the absence of a doctor at the scene of the accident all accident casualties should be conveyed direct to the Cumberland Infirmary, but that if a doctor was present any instructions he issued regarding the disposal of the casualties should be carried out.

In order that drivers should be adequately prepared to meet severe weather conditions, arrangements were made for advance warnings of extreme weather to be passed by the Meteorological Office to the Bush Brow Control Station from where they are broadcast by radio-telephone to all other stations in the county.

Radio

After prolonged negotiation planning permission was obtained for the erection of an aerial on the roof at the Cumberland Infirmary, Carlisle, to replace the arrangement at No. 11, Portland Square, Carlisle. The increased height of the aerial has resulted in a big improvement in reception in the district round Carlisle and especially between Wigton and Thursby and in the Longtown area.

The radio equipment installed in the Casualty Department and Ambulance Transport Office at the Cumberland Infirmary

has fully proved its worth as ambulance crews are now able, as a matter of routine, to talk direct to the Casualty Surgeon and give an appreciation of the patient's condition so that arrangements for the reception of the casualty can be made while the patient is still en route to hospital. There is also the closest co-operation between the hospital Ambulance Transport Officer and the Controller at the Bush Brow Control Station and I feel sure that this has contributed greatly to the smooth running efficiency of the service in this area.

Towards the end of the year the radio equipment formerly housed in the Electricity Board premises on Moota Fell was transferred to new premises with masts erected a short distance away for the County Highways Department. Again, the subsequent increase in aerial height has resulted in improved reception all round.

Similar arrangements were envisaged for the equipment on Ivy Hill, Egremont, but have been superseded by plans of the Independent Television Authority to build a station on this site. These plans provide for the housing of the County Council radio equipment in their building and also for the use of their mast.

Vehicles

During the year one ambulance and two dual purpose vehicles were purchased, replacing vehicles which it was no longer economically sound to keep in service, and a third dual purpose vehicle, additional to the fleet, was purchased to be stationed at Maryport. The total fleet is now 38 vehicles with an average age of four years.

As it is the authority's policy that vehicles for disposal should first be offered to voluntary organisations before being offered for sale by public tender one ambulance was sold to the Workington Branch of the St. John's Ambulance Brigade at a nominal figure. The Brigade can now more fully discharge its local functions, including attendances with First Aid Equipment at football matches. Two dual purpose vehicles were similarly sold to the Workington Methodist Youth Leader for the use of his Group, whose activities include mountain rescue work.

Training

As a follow-up to the course in Advanced First Aid held in the autumn of last year each driver in West Cumberland spent a week in the Casualty Department of the West Cumberland Hospital. A further course in Advanced First Aid was held at the Cumberland Infirmary, Carlisle, for all East Cumberland personnel to which neighbouring authorities were invited to send drivers. The lectures were, in the main, designed to give the staff a better understanding of the problems involved in modern accidents involving multiple injuries to patients, to assess the situation at the scene, and to observe any changes in the condition of the patient being conveyed to hospital. Thus, besides being able to radio an appreciation of the condition of the patient to the Casualty Surgeon, (on arrival) they can give him a full account of all the circumstances obtained at the scene. Lectures on medical and childhood emergencies and emergency midwifery were also included. I am indebted to the hospital consultants who gave the lectures and to the Hospital Management Committee for putting their training facilities at our disposal. These lectures are, I am sure, of great benefit to the ambulance staff and can only lead to close and harmonious working between them and hospital staff.

A short course for Hospital Car Service drivers was held under the aegis of the British Red Cross Society at the Cumberland Infirmary in October. This course, the first of its kind to be held in the county, was designed to give these drivers a knowledge of what is required to promote the comfort and well-being of geriatric and physiotherapy patients while being conveyed to hospital, as it is with these two groups of people that members of the Hospital Car Service are chiefly concerned. A lecture and film on "Safe Driving" was also included, followed by general discussion. Approximately 80% of drivers attended and all agreed that it had been most informative and worthwhile. A further short course is to be held, this time in West Cumberland.

Births in Ambulances

Included in the Advanced Training Course is instruction on the action to be taken in cases of emergency midwifery. The value of this instruction can be gauged from the fact that during the year eight mothers were delivered in ambulances with untoward incident. I think one must accept that, in spite of all the health education measures, this type of case is bound to occur in such a rural county as Cumberland.

Premises

In East Cumberland a new station was opened at Halfway House, Penrith, which replaced the rented premises previously used as a station at Myers Lane, Penrith. The station, which is well located for future motorway access, was built in conjunction with a new County Fire Station and, in order to keep operating costs to a minimum, both services share common facilities, which includes messing arrangements. This works very well. The station which is a complete contrast to the previous premises, is very much appreciated by the Officer in Charge and the seven drivers. One advantage is the markedly increased standard of vehicle cleanliness which is now possible. Two staff houses have also been provided, one for the Officer-in-Charge and one for a driver/attendant.

A request from the British Red Cross Society that their Penrith detachment be allowed the use of a room at the station on two evenings a week for training purposes was agreed to and use of the room commenced in September. In addition some of their equipment is housed on the station as well as that of the Penrith Mountain Rescue Team. Only a nominal rent is charged.

It is a source of satisfaction that the Committee encourage the voluntary workers wherever possible and I am certain that such action is to the benefit of all concerned.

Because of parking difficulties for employees with cars at Distington Ambulance Station, a parking space had to be provided at the rear of the station and, at the same time, land was also acquired to permit any future extension of this station.

Hospital Car Service

The work done by the Hospital Car Service shows another big increase. The service given by these drivers, who are Associate Members of the British Red Cross Society, is invaluable and I am most grateful to them and to the members of the Red Cross Society who do the administrative work. Although the number of drivers has increased more are still needed, especially in West Cumberland.

Mrs. Fleming Smith, County Director, British Red Cross Society, has kindly submitted the following comments:—

“1966 has been another busy year for the Hospital Car Drivers who voluntarily give their time to carrying out this service.

“In October a “Teach-in” was held in Carlisle which was well attended.

“A recruiting campaign was successfully run and we have 98 car drivers now, who have covered 578,238 miles, an increase of 222,120 miles over 1965.

“The enthusiasm of the drivers is reflected in the fact that very few drivers leave the Service. Their assistance to patients is not limited to helping them in and out of cars, but extends to helping them in hospital and at home, even to lighting fires. Drivers identify themselves with individual cases and such personal service is very beneficial to the patients.

“We would like to extend our thanks to all car drivers for their kindness and attention to duty in carrying on this valuable addition to the Ambulance Service.”

Lady Garvagh, a Hospital Car Driver who operates from Keswick, comments:—

“I think that the drivers get great satisfaction from being part of a service which is essential in our scattered community. It is most efficiently run and there is no doubt that it is appreciated by the patients. To me it is surprising how many

people I meet who do not know of the service. I feel it is a great privilege to be part of this great service to the community”.

Mrs. Melville, a Hospital Car Operator from Aspatria, writes as follows:—

“I would like to take this opportunity of saying how much I enjoy doing the Hospital Car Service. It certainly was a challenge to me at first meeting so many different kinds of people from all walks of life. The most embarrassing situations arose on occasion when patients had escorts and no seats were allocated for them in the car. However, that situation seems to have eased now. The reason I believe I enjoy this work is because it enables me to do more driving which I enjoy immensely and, at the same time, being able to do a useful service which I think is worthwhile. At the end of the week I can enjoy relaxation, happy with the thought that I have given some time to those more unfortunate than myself.

“I am very grateful to be able to do this service and hope to continue as long as I am able.”

General

It is pleasing to note that this service is now being looked to by the Education Department for instruction in the modern life saving techniques in schools and I am certain this teaching role should be extended wherever possible as the staff have a wealth of experience to supplement that which can be taught from text books.

The increased use of the Hospital Car Service, which is a flexible unit capable of rapid expansion or contraction, has made it possible to keep the increase in staff to a minimum, in spite of the ever increasing volume of work, and allows the County Council to concentrate its resources on providing a corps of highly trained staff with vehicles equipped with two-way radio and modern life-saving equipment. Whatever future developments lie ahead for the Ambulance Service I feel that this pattern now being evolved in Cumberland should remain.

I am indebted to Mr. P. A. M. Weston, F.R.C.S., Consultant Surgeon in charge of Casualty Department, Cumberland Infirmary, Carlisle, for the following report:—

“I would like to start by saying as in previous years, how much we in hospital appreciate the cheerful and willing co-operation of the ambulance drivers.

“I am delighted that the links between the hospital and the ambulance service have been made even closer by the following measures—

1. The positioning of a radio in the Transport Officer's room in the hospital with a sub-station in the casualty department has enormously facilitated the efficient collection and disposal of patients. In addition, it has allowed us on a small number of occasions to speak direct with ambulance drivers who were bringing seriously ill patients from a long distance. The nursing staff are slowly becoming familiar with the routine on the radio and I think that in the coming summer it will prove even more valuable now that we are more familiar with its use.

2. Another advanced first-aid course has been held for the ambulance drivers and this provides not only an opportunity of getting to know the drivers better but a forum for discussion of mutual problems such as the unification of stretcher and trolley design, the new patterns of splints for fractures, including the Jet splints (which have proved so outstandingly successful) and so on.

3. The setting up of a resuscitation unit which has already been used twice and I hope will prove of further value in the coming summer. I believe this unit should be regarded not so much as a life saving measure but as a means of starting resuscitation a little bit earlier so that the patient's journey may be made safer and more comfortable. I also believe it has an important function in allowing us from the hospital to learn the problems of first-aid as applied by the road side or in an ambulance at first hand.”

I am also grateful to Mr. R. M. Bompas, M.B.E., Group Secretary, West Cumberland Hospital Management Committee for his comments:—

“As the Ambulance Service is provided by the Local Health Authority but the Hospital Service is the main user, it is most satisfactory that excellent liaison has been built up in West Cumberland between the two services. There are many practical problems still to be overcome, largely because so many people are involved who have different needs and points of view. The basic difficulty is how to balance, in each individual case, the reasonable needs of patients against the necessity to control the ever increasing outflow of public funds for this service. The re-organisation of the Hospital Service towards the pattern of the District General Hospital with its concentration of acute work, which has progressed further in West Cumberland than in most parts of the country, means far greater demands on the Ambulance Service. This is part of the price the Nation must pay for improved treatment for patients, as it would be quite impossible to duplicate the special equipment and trained staff now available at the West Cumberland Hospital.

“There is little problem in dealing with the accident and emergency cases and it can be said that Cumberland has a service second to none now that it is directly provided and it should be even better still when the radio liaison has been improved. Now that the high speed ambulance is available, transfers to Newcastle of seriously ill patients who need the facilities of Regional Centres proceed very smoothly.

“A major difficulty for the Hospital Service is to be able to give the Ambulance Service sufficient advance notice of needs to enable the latter to make the most efficient arrangements. Because of the need for beds, it is often necessary to arrange for the quick discharge of patients. Another problem is that patients booked for admission or for an out-patient appointment decide against it or go away without notifying the hospital so that the ambulance has a fruitless journey. Some patients also make their own arrangements for transport even though they have been told that ambulance transport or the hospital car service has been arranged.

"In the case of out-patients, it is essential for economy, that all patients from one area should use one vehicle. An attempt is made to organise bookings accordingly but because of other considerations this is not always possible so some patients have to wait. On other occasions, patients may have to have a fuller investigation or treatment not originally envisaged so that the time they are ready to return is much later than expected. This may mean a longer wait for others which could be specially difficult for mothers expecting to be home in time to deal with children. Sometimes patients get overtired because of the length of the journey when others have to be taken home en route. However, extra vehicles are arranged on occasions, when the waiting time would be really excessive or when a patient needs to be taken home quickly and when necessary, arrangements are made for patients to be given a meal at the hospital. Although some grumbles are heard, it is probably true to say that usually the right decision is reached, bearing in mind both the patients' needs and convenience and the increasing cost to public funds.

"By means of the regular discussion of problems between the two services there is little doubt that any present difficulties on both sides will be overcome so that the service is reasonable from the patients' point of view but, at the same time, is provided only when medically necessary and not merely as a convenience. This should lead to economy though not necessarily to an overall reduction of the ambulance service as many modern developments in the hospitals, as for example the new Day Hospital at Whitehaven, will inevitably increase demand."

The following reports from two Officers in Charge of Stations are of interest.

Mr. J. A. Mossop, Distington Ambulance Station, writes:—

"A pilot scheme was put into operation at Distington Ambulance Station to start this year in July when the first of the fleet of nurses' cars in the Western Area was brought

in for service and mechanical maintenance. Since then I am pleased to report that we have serviced all these vehicles and in addition a complete record of road worthiness has been kept for future reference. It is most gratifying when the nurses themselves comment on the better performance and general condition of their cars. As this work has been fitted in with our normal ambulance repairs with very little extra costs it is not beyond the realm of possibility that this scheme could well be expanded.

“With the replacement of four of our older ambulances the station at Distington is developing quite a “New Look” and the trend is now well set to keep abreast with other services in this streamlined age.

“A word of thanks is justly due to all our Hospital Car Service drivers, not to forget our new entrants who have joined the ranks of this magnificent service.

“It is noteworthy that out of our weekly classes in First Aid held on the station, we were able to put forward no less than eighteen members who are now undertaking their studies at an advanced level in the Institute of Ambulance Personnel.”

Mr. J. Corry, Penrith Ambulance Station, writes:—

“The routine work of transporting out-patients to the various hospitals, clinics and centres, which account for the bulk of our work, has been continued throughout the year. In order to give the patient the most comfortable journey with the minimum of waiting time close co-ordination of journeys between Penrith and the East Cumberland Control Station at Bush Brow, Carlisle, has been the rule. The radio system plays an ever increasing role in the work of co-ordination.

“The highlight of 1966 at Penrith was the move of the Ambulance Station from Myers Lane to the new building at Halfway House, Penrith. This new station immediately did away with the problem of (a) the temperature in the interior of the ambulances and (b) the keeping dry and aired of blankets, sheets, etc.

"We now have an excellent blanket store and under-floor heating which keeps the interior temperature of the ambulances at a constant 60°F; this in turn benefits the patient in cases of accidental hypothermia, etc.

"Prior to the occupation of the premises some doubts were held that shared facilities might have their difficulties but I am pleased to report that this has not been so. In fact my colleague, the Station Officer at the Fire Station, Penrith, agrees that both services have benefited from the close contact with each other in the form of lectures and talks.

"Public relations played a big part in our work during 1966, taking the form of visits to the new station of 188 members of the public who came as members of the following organisations: Penrith Urban District Council, Women's Institutes, Church Groups, Youth Clubs, School Parties, etc.

"The British Red Cross Society have held their training sessions weekly since September 19th in the station and because of this a close link has been forged between the Voluntary Aid Society and the Ambulance Service. The latest addition is that the Penrith Mountain Rescue Team are now keeping their equipment with us.

"Emergency cover for a large area of North Westmorland was provided from this station during the past year, most of the calls concerned accidents on the two trunk roads, the A6 and A66. In this respect the radio link now established at the Cumberland Infirmary has proved to be a great asset. On several occasions this has been used to save life by the driver attendant being able to speak to the Consultant at the hospital.

"It has been my practice during 1966 to visit local hospitals and their departments and thus establish a meeting point where minor difficulties, etc., can be ironed out to the satisfaction of both parties.

"Also during 1966 the Ambulance Service moved into the field of Prevention and Instruction.

"All the Residential Home units in this area have been visited and instruction given in the Expired Air Method of resuscitation; similar visits have been made to the Women's Institutes and Youth Groups in the area.

"Information has been forwarded to the Northern Area Office regarding elderly persons being left alone when their partner was admitted to hospital. Also details as to the temperature of the house on discharge from hospital.

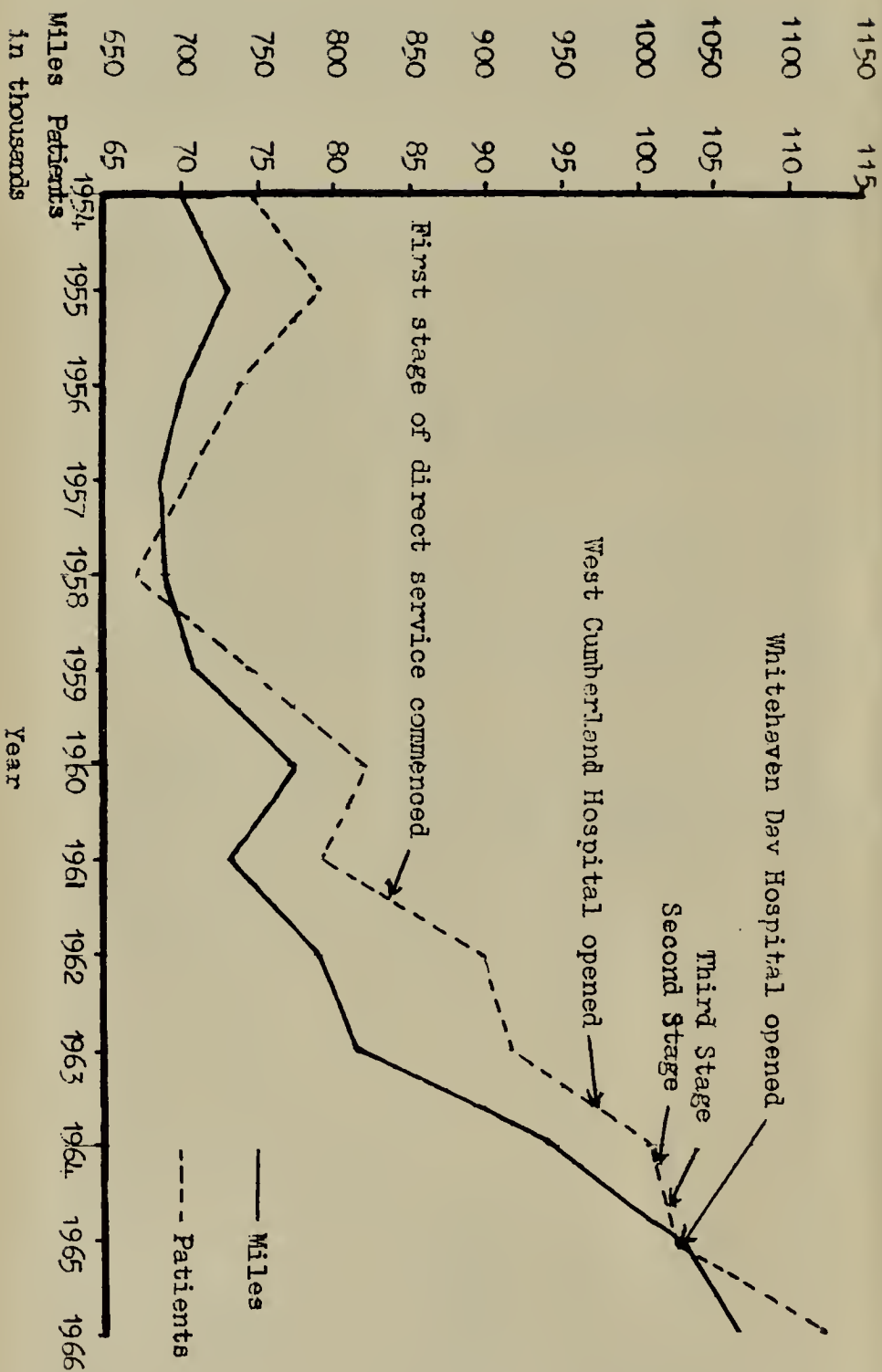
"The Hospital Car Service operators deserve a special mention in this Report for the excellent way they have carried out this service to the patients. They have always been sympathetic, understanding and willing to turn out, sometimes at short notice.

"The staff at Penrith have all received a course of advanced training at the Cumberland Infirmary and have also all qualified as Artificial Respiration Operators by passing the Royal Life Saving Society Advanced Examination.

"The aspect of the service which has particularly pleased me is the disappearance of independent units and the establishing of a team with the necessary spirit with patient welfare as its number one priority. This team has, as its members, doctors, hospital staffs, the ambulance service and the welfare services in the county".

Ambulances			Sitting-Case Cars			Hospital Car Service			Summary of all Services		
			Total Patients	Total Mileage	Total Patients	Total Mileage	Total Patients	Total Mileage	Patients	Mileage	
1965	A.	...	2946	33477	26081	199371	342	6613	29369	239461	
	D.	...	47805	439706	—	—	25434	349505	73239	789211	
			50751	473183	26081	199371	25776	356118	102608	1028672	
1966	A.	...	650	16377	3567	31304	843	22726	5060	70407	
	D.	...	56913	490814	—	—	43612	555512	100525	1046326	
			57563	507191	3567	31304	44455	578238	105585	1116733	
Increase or decrease compared with previous year			increase	increase	decrease	decrease	increase	increase	increase	increase	
		...	6812	34008	22514	168067	18679	222120	2977	88061	

CUMBERLAND—GROWTH IN THE USE OF THE AMBULANCE SERVICE



CIVIL DEFENCE

AMBULANCE AND FIRST-AID SECTION

Training throughout the County has been confined in the main to Advanced Training although a steady flow of recruits have been undertaking Standard Training.

Three life saving and deployment exercises were held during the year in which the Ambulance and First-Aid Section played a notable part in casualty collection and co-operation with Forward Medical Aid Units and Rest Centres. A large movement and control exercise during the weekend 8th/9th October, 1966, was held at Bishopbriggs, near Glasgow, in which all vehicles of the Section participated. Considerable experience was gained in convoy procedures.

A competitive exercise among First-Aid teams throughout the Division was held during the year, the Border team being awarded the proficiency trophy which was presented by the Chairman of the County Council.

Co-operation with the County Ambulance Service has been maintained, selected volunteers assisting at Ambulance Stations. The experience gained has proved most useful and all members expressed their appreciation for the opportunity given them to be associated with the County Service.

Recruitment has by design been permitted to slow down in view of the re-organisation of the Corps, details of which have now been made known in Civil Defence Circular 1/1967.

In order to effect the provisions of the Circular and ensure that as smooth a transition as possible from the present structure of five Sections to a very much reduced all purpose Corps, is effected, it is proposed to terminate current Section training as from 31st March in order that re-shaping of the Corps may proceed and new training arrangements introduced by the 1st October, 1967.

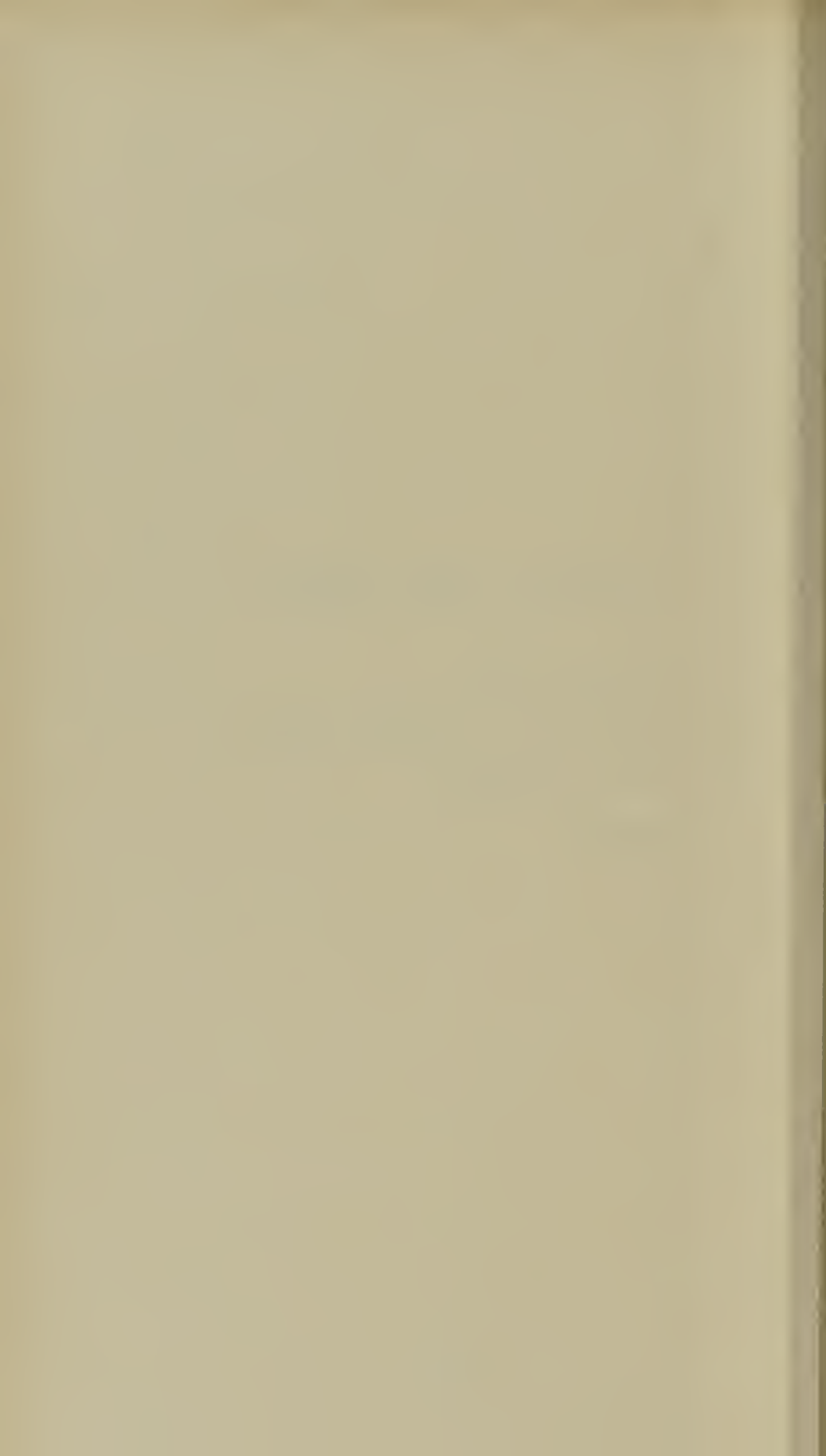
GENERAL PUBLIC HEALTH

Infectious Diseases

Inspection and Supervision of Food

Water and Sewerage

Housing



INFECTIOUS DISEASES

The table of notifications of infectious and other notifiable diseases is shown on page 261.

Last year I commented on two conditions in particular, viz. measles and gastro-intestinal infections. I am glad to say that for 1966 the latter group of diseases was not prominent there being no recurrence of paratyphoid fever and a return to a low level of notification of dysentery. Complacency would be the one highly undesirable result of these figures. It cannot be too often repeated or too clearly, that by far the most important defence against gastro-intestinal infections is the continuing high standard of personal hygiene, especially hand hygiene in connection with food handling. This is not in the main, a group of infections which can be controlled by immunisation procedures.

I am very sorry that it must be recorded that no substantial progress has been made in 1966 with regard to the provision of highly essential sanitary facilities in certain strategic spots in the Lake District where many visitors come for holidays in caravans and tents.

1966 saw a lower incidence of measles than the previous year. This is in keeping with the usual cycle of this disease. I have commented already in the section of this report on vaccination and immunisation on the situation with regard to measles vaccine. It does appear that a great deal depends on the production of the vaccine which occasions minimal reaction problems in children receiving it.

An increase in the notification of puerperal pyrexia is a timely reminder that infection at the time of confinement is still to be taken account of and carefully guarded against.

Scarlet fever shows the highest notification for several years, and it will be seen that this was particularly associated with an outbreak at Millom. I know that my colleague, Dr. W. S. Slater, Medical Officer of Health, Millom R.D. followed this closely, and noted certain features of the throat infection which were more

familiar a good many years ago. Again we are reminded sharply that the streptococcus is an organism demanding continuing respectful treatment.

The control of infectious diseases, apart from the large contribution of vaccination and immunisation schemes has become a smaller part of the field of work of the medical officer of health. It remains however, a part which requires a trained and acute medical eye upon it and continuing close observation. In some respects this is the more so since many medical officers of health of today have very little, if any, personal experience of some of the notifiable infectious diseases.

	Scarlet Fever	Whooping Cough	Poliomyelitis	Measles	Dysentery	Meningococcal Infection	Acute Pneumonia	Acute Encephalitis Infective	Post Infectious	Enteric or Typhoid Fever	Paratyphoid Fever	Erysipelas	Food Poisoning	Tuberculosis Respiratory	Meninges and C.N.S.	Other T.B.	Puerperal Pyrexia	Ophthalmia Neonatorum
URBAN DISTRICTS—																		
Workington	7	3	—	214	—	—	—	—	—	—	—	—	—	11	—	—	5	—
Whitehaven	8	3	—	23	3	1	18	—	—	1	—	1	—	9	—	—	2	—
Cockermouth	3	2	—	7	—	—	—	—	—	—	—	—	1	1	—	—	2	—
Keswick	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Maryport	25	1	—	47	—	—	3	—	—	—	—	1	—	4	—	1	1	—
Penrith	—	4	—	80	—	—	2	—	—	—	—	1	1	3	—	—	3	—
RURAL DISTRICTS—																		
Alston	—	—	—	88	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Border	8	36	—	291	3	—	1	—	—	—	—	—	—	5	—	2	—	—
Cockermouth	33	7	—	91	6	—	1	—	—	—	—	—	2	2	—	—	1	—
Ennerdale	10	18	—	77	—	—	2	—	—	—	—	—	—	11	—	1	3	—
Millom	88	2	—	48	2	—	22	—	—	—	—	1	—	3	—	—	1	—
Penrith	—	1	—	87	—	—	—	—	—	—	—	—	—	2	—	1	—	—
Wigton	2	6	—	130	—	—	—	—	—	—	—	—	—	3	—	—	—	—
TOTAL FOR YEAR	184	83	—	1183	14	1	49	—	—	1	—	4	4	54	—	13	33	—
1965	76	17	—	3480	261	—	9	—	—	—	31	7	10	56	2	10	7	—
1964	119	152	—	1064	12	—	16	—	—	—	1	4	4	73	2	13	2	—
1963	23	119	1	1836	50	5	22	—	—	1	—	4	31	76	1	12	12	2
1962	35	39	2	2485	149	6	40	—	1	—	—	4	40	94	1	12	33	—
1961	57	72	4	2204	149	—	85	—	—	—	—	10	15	80	—	15	21	—

INSPECTION AND SUPERVISION OF FOOD

I am indebted to the Chief Inspector of Weights and Measures for the following report:—

FOOD AND DRUGS ACT, 1955

Summary of work done under the above Act during the year ended 31st December, 1966

Total Samples Obtained		Genuine		Unsatisfactory	
Milk	Other Foods	Milk	Other Foods	Milk	Other Foods
538	247	507	237	31	10
785		744		41	

During the year 785 samples were obtained, consisting of 538 milk and 247 samples of various foods and drugs. The samples of food covered as wide a range as possible whilst the drugs consisted of proprietary medicines and B.P. and B.P.C. drugs available to the public.

All the samples of food and drugs and 79 of the milk samples were submitted to the Public Analyst. The milk samples which were known to be from one source of supply were also tested for the presence of antibiotics. In only one instance was the presence of penicillin detected but the quantity present (0.02 international units per million) was less than the amount usually considered to be unsatisfactory (0.05 I.U. per mil.)

On the 1st August, 1966 this authority entered into a nationwide scheme for making more searching tests for residues of insecticides and pesticides in foodstuffs but, before this date samples of fresh fruit and vegetables from this authority were already being tested for such residues. The new scheme embraces most foods which at one time or another might possibly be contaminated by pesticides or insecticides, a few examples being breakfast cereals, beef, margarine and eggs. Each authority taking part in the scheme has been instructed to take samples of specific articles of food in order to avoid duplication, the number

of samples taken being in proportion to the size of the authority. The number of samples scheduled to be taken in Cumberland is ten, spread over three four monthly periods. Up to the end of the year five samples of food, namely beef, margarine, breakfast cereal, apples and brussel sprouts had been submitted for analysis. The results of the tests were regarded as satisfactory, being negative on the biological test and also on the test for organo-chlorine residues with the exception of the apples (Worcester) which gave a result of less than 0.02 parts per million.

The 459 milk samples not submitted to the Public Analyst were tested by the Sampling Officers. The average quality of these samples, including 8 slightly below standard, was 3.6% fat and 8.66% solids-not-fat compared to the presumptive standard of 3.0% and 8.5% respectively.

The percentage of unsatisfactory samples, of the total number obtained, was 5.2. Taking the milk samples and other food-stuffs separately, 5.8% of the milk samples were unsatisfactory and of the remaining samples of food 4% were either of unsatisfactory quality or incorrectly labelled. Referring to the 5.8% unsatisfactory milk samples it should be borne in mind that not all of them were from different sources; there were 31 unsatisfactory samples, 20 producers and dairymen being involved.

The unsatisfactory samples were dealt with as follows:—

Milk:

A sample of milk obtained from a retail dairyman was deficient in fat. The dairyman was in doubt as to which of three producers had supplied him with this particular consignment, therefore, arrangements were made with the dairyman for samples to be taken from each of his three bulk supplies before he commenced bottling. Two producers were eliminated but milk supplied by the third producer was deficient in fat. Two further samples taken at the farm from churns of milk awaiting collection by the dairyman were also deficient in fat. "Appeal to cow" samples taken at the farm were of satisfactory quality. Legal proceedings were instituted against the farmer for two offences—one concerning the churn from which a sample was taken at the dairy and the other concerning the two churns at the farm. The

farmer was fined a total of £20 plus £12/3/0 costs. This is an example of four unsatisfactory samples but only one producer was responsible.

Seven samples, all from the same source, contained added water in amounts ranging from 8.2% to 23.5%. The producer was fined £30 plus £17/10/0 costs.

Two samples of milk each contained 6.3% of added water and the producer was fined £10 plus £8/5/0 costs.

The above cases of watered milk were taken as a result of complaints received from dairies to which the producers consigned their milk and which indicated that these were not isolated instances of water getting into the milk by accident.

Two complaints were received from consumers that milk delivered to them appeared to be contaminated and two samples of the milk were submitted to the Analyst. He reported that discolourisation in the milk was due to both samples being contaminated with blood.

Enquiries revealed that on the day the samples were taken the producer had included the milk of a cow which had calved a week earlier. The producer was cautioned that under no circumstances should any milk be put into supplies for human consumption if it could possibly have been contaminated in any way.

One sample contained a small amount of extraneous water but did not warrant legal proceedings and a further sample taken later was satisfactory.

Similarly another sample was deficient in solids-not-fat but due to the milk being rather sour the determination of the freezing point did not provide a reliable indication of the presence of extraneous water. A further sample proved to be of satisfactory quality.

There were four cases of milk being genuine but below standard in solids-not-fat and two samples deficient in fat. In these instances the attention of the producers was drawn to the results to enable them to take steps to improve the quality of the milk.

Unsatisfactory food other than milk:

The number of samples of food, other than milk, certified by the Analyst to have irregularities was 10.

A sample of potted meat contained 89% of meat, compared to 95% which the Analyst was of the opinion this product should contain, the latter figure being based on various reports on meat products issued by the Food Standards Committee. As the price charged was reasonable when compared to prices at other shops for a similar type of product, no further action was taken.

Tinned steak was deficient in meat but no further action was taken because this particular brand was no longer being imported and also because the result of analysis of another tin from the same consignment was satisfactory.

Two samples of rum butter (different makes) were certified to be deficient in rum. This matter had previously been drawn to the attention of one of the manufacturers but without any apparent effect. There is no legal standard covering rum butter but the Public Analyst was of the opinion that a reasonable amount of rum would be 2% based upon the average results of the analyses of samples of rum butter throughout the country. The sample in question contained only 0.7% of rum and it was decided to institute legal proceedings against the manufacturer. The magistrates were not convinced, on the evidence placed before them, that 2% was a minimum standard. In the second sample enquiries indicated that a reasonable amount of rum had been used but the deficiency appeared to be due to age of the product and incorrect mixing. The manufacturer agreed to make the rum butter in smaller quantities to expedite turnover and also to improve his method of mixing. Apart from the somewhat controversial question of rum content it is advisable for samples of this substance to be analysed to ensure that butter is in fact being used and not margarine.

A sample of halibut liver oil capsules were deficient in Vitamin A. Enquiries revealed that the capsules had been in the shop for one to two years and from a code marking on the packet the manufacturers identified the capsules as being six and

a half years old. In the case of halibut oil capsules the British Pharmacopoeia states, "Halibut liver oil capsules should be protected from the light and stored in a cool place. When stored under these conditions they may be expected to retain their potency for at least three years after the date of preparation". As it was impossible to know under what conditions the capsules had been stored it was decided not to institute legal proceedings against the manufacturers. It would be an advantage if such products were marked with the date of manufacture and an indication of the normal "shelf" life then this kind of trouble would not occur. Many shopkeepers deal in this type of article and other proprietary medicines as a side-line without giving much thought to the adverse effect of incorrect storage or to the time factor.

A sample of whisky proved to be adulterated with water and the licensee was prosecuted and fined £10.

Malt Vinegar, although of satisfactory quality, did not have a declaration of the presence of salt and the manufacturers were notified of the labelling infringement.

Some dried skimmed milk contained 7.8% of water, the permitted limit being 5.0%. The Analyst expressed an opinion that, as this was a formal sample and had been divided and dried, milk being hygroscopic, it was possible that the milk powder in the original container may have been satisfactory. An unopened packet from the same stock was sent to the Analyst but the result of analysis was practically the same as that of the original sample. This article had been in stock for some time which would probably account for the presence of extraneous water.

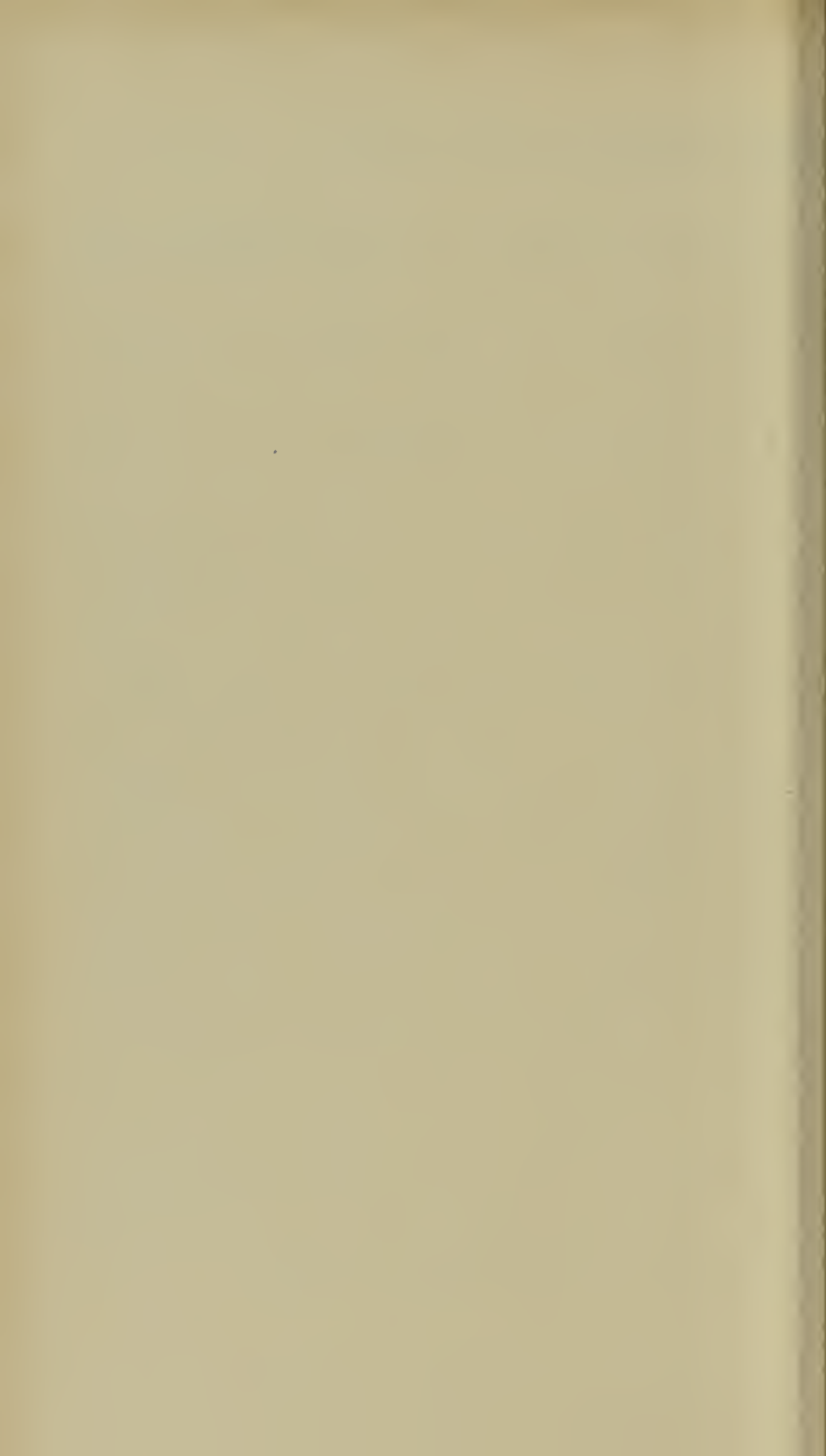
complaints regarding unsatisfactory food other than articles submitted for analysis:

A number of complaints were received from members of the public concerning unsatisfactory food and the following were the most serious.

A meat and potato pie which contained pieces of glass resulted in the bakers being fined £10.

A firm of food manufacturers was fined £20 in respect of liver sausage which contained an elastic band.

Another complaint was in respect of a sweet confection (a snowball) which contained a piece of metal. The article had been manufactured in Scotland but the Food and Drugs Act, administered by this authority, does not apply to Scotland. To overcome this difficulty the following procedure was adopted. The wholesale merchants responsible for importing the unsatisfactory article into England were charged with the offence. At the local hearing they named the firm in Scotland as the actual offenders. The magistrates agreed that the offence was due to the act or default of the Scottish firm and, following the statutory requirements, ordered details of the case to be forwarded to the Ministry of Agriculture, Fisheries and Food to enable appropriate action to be taken in Scotland. Apart from being informed that the matter was being dealt with by the Corporation of Glasgow Health Department nothing more was heard on the subject. Upon enquiry being made it was found that after inspection of the manufacturing premises by the Health Department who reported their findings to the Procurator-Fiscal of Police, the latter considered that should the manufacturers contest the case it would be very expensive to bring all the witnesses to Glasgow and consequently thought a warning would suffice. As a point of interest the manufacturers sent a representative to the hearing in Keswick Magistrates' Court and they wanted to plead "guilty" and thus get it over and done with but it was not permissible to do so owing, as previously stated, to the Act not being applicable to Scotland.



RURAL WATER SUPPLIES & SEWERAGE ACTS 1944-1961

Water Supplies

There were five new schemes submitted during the year and all were small water main extension schemes costing between £900 and £2,500. (Details are set out in the following schedule). The only other item concerning water schemes is the notification of the following grants:—

(i) Carlisle Corporation—Major Capital Expenditure Programme—Water Scheme. Ministry grants of half yearly payments of £2,385, £712 and £1,123 respectively for 30 years in respect of the first three stages of this major scheme.

(ii) Eden Water Board—Eden Borehole Scheme. Ministry grant of £577 per half year for 30 years.

The County Council decided to match the Ministry grant in all cases.

Sewerage Schemes

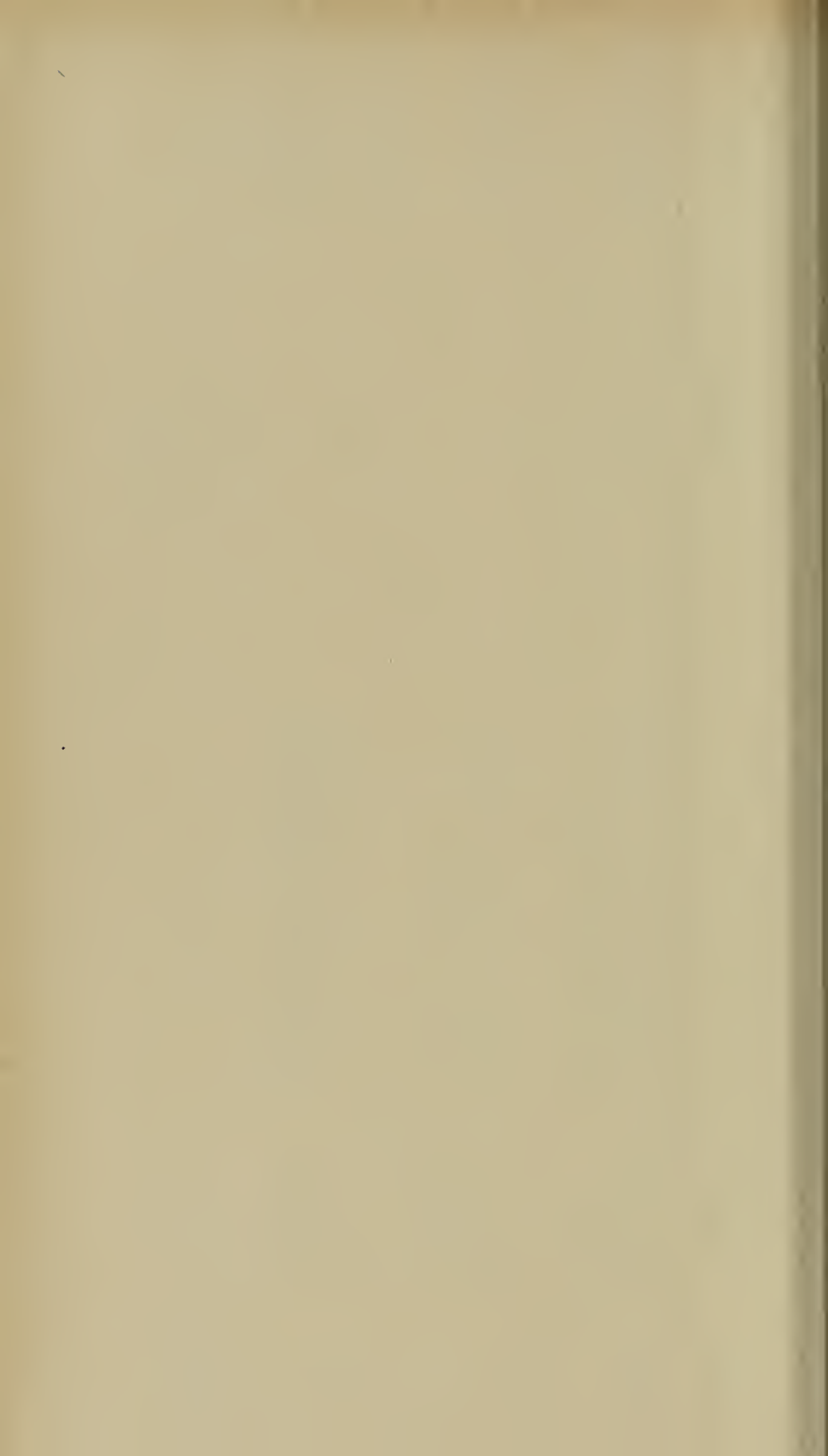
Three new schemes were submitted—two from the Border Rural District Council and one from Penrith Rural District Council. All three were approved as sound and adequate subject to some engineering variations on the Penrith scheme. There were no grants notified for sewerage schemes during the year.

Water Schemes

Scheme Submitted by	Name of Scheme	General Outline	Estimate or Final Cost	Remarks
Eden Water Board	New Main to Scales, Kirkoswald	A new 3" main to bring a supply for the first time to Scales and Nethersceugh and 3 other properties.	£2,500	Approved as sound and adequate.
Eden Water Board	Causeway House to Wreay Hall	Mains extension		Approved as sound and adequate.
Eden Water Board	The Raise, Alston.	Mains extension	£1,500	Approved as sound and adequate.
Eden Water Board	Extension to Manor House,	Mains extension	£1,000	Approved as sound and adequate.
W.C. Water Board	Alston Supply to farms in Rosley area	Mains extension	£900	Approved as sound and adequate.

Sewerage Schemes

Scheme Submitted by	Name of Scheme	General Outline	Estimate or Final Cost	Remarks
Border R.D.C.	Walton Sewage Disposal Scheme	A scheme to lay a system of 6" sewers and provide treatment works to serve the village of Walton.	£15,656	Approved as sound and adequate.
Border R.D.C.	Heads Nook Sewerage and Sewage Disposal Scheme	A scheme to lay a new system of sewers to serve Heads Nook and provide a new treatment plant on a site West of the village.		Approved as sound and adequate.
Penrith R.D.C.	Ainstable Sewerage and Sewage Disposal Scheme	A revised variation to a scheme submitted in 1950 for the extension of the sewage system for Ainstable and for providing treatment works on a new site.	£27,900	Approved as sound and adequate subject to some engineering observations.



HOUSING RETURNS FOR THE COUNTY OF CUMBERLAND

For year ended 31st December, 1966

(N.B.—Corresponding figures for 1965 are shown in brackets)

Population — 1951
(Census) — 1961

	Alston R.D.C.	Border R.D.C.	Cocker- mouth R.D.C.	Ennerdale R.D.C.	Millom R.D.C.	Penrith R.D.C.	Wigton R.D.C.	White- haven Boro'	Working- ton Boro'	Cocker- mouth U.D.C.	Kewick U.D.C.	Maryport U.D.C.	Penrith U.D.C.	County Total
A 1 Total number of occupied dwelling houses in the district ...	2,327 2,198 831 (829)	29,845 29,647 9,172 (9,084)	20,455 20,966 7,074 (7,012)	29,676 30,870 9,907 (9,882)	13,428 15,094 4,607 (4,595)	11,723 11,606 3,642 (3,712)	23,733 21,868 7,480 (7,365)	24,624 27,541 8,074 (8,044)	28,891 29,552 9,414 (9,464)	5,235 5,827 2,262 (2,137)	4,868 4,765 1,590 (1,720)	12,180 12,393 4,226 (4,093)	10,492 10,927 3,607 (3,595)	205,847 223,202 71,886 (71,532)
2 Total number of occupied dwelling houses subject to Demolition Orders, Closing Orders or Undertakings ...	1 (1)	— (—)	7 (6)	143 (143)	34 (1)	10 (12)	34 (13)	60 (28)	3 (6)	8 (12)	— (—)	38 (54)	4 (26)	345 (302)
3 Estimated number of houses (exclusive of above) which are unfit for habitation and cannot be made fit at a reasonable cost: ...	13 (13)	315 (326)	159 (154)	319 (376)	251 (264)	75 (80)	288 (273)	10 (100)	NK (NK)	115 (127)	— (3)	80 (85)	96 (65)	1,721 (1,866)
4 Estimated number of sub-standard houses (exclusive of above) which could be repaired and made fit: ...	50 (50)	490 (250)	NK (NK)	NK (NK)	197 (198)	400 (430)	1,074 (1,158)	20 (NK)	NK (NK)	17 (20)	50 (90)	55 (59)	20 (50)	2,373 (2,575)
5 Number of houses found to be overcrowded: ...	5 (6)	15 (22)	2 (1)	— (—)	6 (7)	10 (16)	— (2)	— (—)	NK (10)	— (—)	— (—)	— (—)	3 (7)	41 (71)
B WAITING LISTS Total number of valid applicants on Council's waiting list exclusive of those living in houses under A 2 and 3 above ...	38 (12)	190 (220)	486 (460)	472 (498)	191 (161)	*88 (*61)	470 (456)	526 (677)	700 (720)	173 (141)	54 (101)	323 (269)	275 (143)	3,986 (3,919)
C NEW DWELLINGS COMPLETED DURING THE YEAR														
1 By or for the Council—								2+						
For aged persons ...	— (—)	8 (20)	6 (—)	37 (—)	15 (14)	— (6)	14 (16)	16 (—)	13 (16)	6 (15)	— (—)	— (35)	— (—)	117 (122)
For aged persons grouped with welfare facilities ...	— (12)	— (—)	— (—)	22 (—)	— (—)	— (—)	— (—)	— (—)	24 (—)	— (21)	— (—)	— (—)	— (21)	46 (54)
For agricultural workers: ...	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
General purpose dwellings ...	— (—)	33 (11)	14 (9)	42 (15)	— (—)	— (—)	52 (93)	112 (74)	71 (86)	— (36)	18 (24)	20 (86)	49 (—)	411 (434)
2 Private building ...	2 (—)	98 (83)	43 (42)	54 (70)	11 (42)	22 (22)	38 (40)	62 (84)	45 (56)	47 (24)	23 (17)	49 (23)	13 (56)	507 (561)
Total of 1 and 2 ...	2 (14)	139 (114)	63 (51)	155 (85)	26 (56)	22 (28)	104 (149)	192 (158)	153 (158)	53 (96)	41 (41)	69 (144)	62 (77)	1,081 (1,171)
D 1 Number of houses for which application was made by private persons for Grants. (Improvement and Standard Grants). ...	14 (10)	69 (79)	84 (64)	65 (85)	30 (59)	46 (49)	52 (69)	18 (26)	75 (66)	4 (2)	9 (12)	30 (35)	17 (30)	513 (586)
2 Number of houses for which grants were approved ...	9 (10)	74 (78)	83 (63)	64 (51)	30 (50)	44 (45)	51 (63)	17 (25)	72 (60)	4 (2)	9 (12)	30 (34)	12 (28)	499 (521)
3 Number of houses where improvements were carried out and grants paid ...	11 (11)	65 (75)	66 (64)	58 (65)	34 (37)	35 (41)	57 (50)	17 (22)	38 (51)	3 (6)	14 (8)	— (18)	15 (13)	413 (461)
4 Number of houses purchased or taken over by the Council with a view to improvement or conversion ...	— (—)	26 (1)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (1)	— (—)	26 (2)
5 Number of houses improved by the Council—														
(i) with grant ...	— (—)	42 (1)	— (34)	48 (—)	— (—)	— (—)	— (—)	1 (—)	— (—)	— (—)	— (—)	— (—)	1 (—)	92 (35)
(ii) without grant ...	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
E HOUSING PROGRAMME FOR ENSUING YEAR—														
1 Dwellings to be built by or for the Council—								2+						
For aged persons ...	— (—)	12 (8)	9 (19)	40 (57)	13 (28)	22 (22)	25 (27)	— (16)	8 (—)	— (6)	— (—)	— (34)	— (—)	131 (217)
For aged persons grouped with welfare facilities ...	— (—)	— (—)	— (—)	— (22)	10 (—)	— (—)	10 (10)	— (—)	— (24)	— (—)	— (—)	20 (20)	— (—)	40 (76)
For agricultural workers ...	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)	— (—)
General purpose dwellings ...	42 (46)	8 (33)	— (24)	310 (226)	6 (—)	8 (6)	— (56)	70 (120)	25 (285)	48 (48)	42 (38)	50 (50)	20 (24)	599 (956)
2 Private building ...	4 (4)	NK (NK)	45 (55)	50 (60)	26 (25)	20 (24)	45 (50)	50 (80)	100 (50)	25 (50)	30 (41)	35 (45)	20 (20)	450 (504)
Total of 1 and 2 ...	46 (50)	20 (41)	54 (98)	400 (365)	55 (53)	50 (64)	104 (143)	122 (216)	133 (359)	73 (104)	72 (79)	61 (149)	30 (44)	1,220 (1,753)

* Old People only.

† Disabled.

APPENDICES

- I. Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland.**
- II. Annual Report on Tuberculosis and Other Chest Diseases in East Cumberland.**
- III. Mass Radiography.**
- IV. County Council Clinics.**



APPENDIX I

Annual Report on Tuberculosis and Other Chest Diseases in West Cumberland in 1966 by Dr. R. Hambridge

The Chest Service has continued in the pattern established by the end of 1965. Outpatient sessions have been held at the West Cumberland Hospital, and Workington Infirmary, where cases of all types of respiratory illness have been seen. Although the Tuberculosis Register for this area remains at something in excess of 1,000, the number of cases of tuberculosis requiring either in or out-patient treatment is now far less than non-tuberculous conditions such as "chronic bronchitis", asthma and the wide range of ventilatory defects now being recognised; cancer of the lung and the less common suppurative and infective conditions leading to chronic respiratory illness. This report is confined to tuberculous conditions only, as no accurate statistical material is available for those conditions not commonly classified as communicable disease.

New Cases:

During the year 44 cases of respiratory tuberculosis and 9 cases of various non-respiratory forms of the disease were notified totalling 53 cases (64 in 1965: 70 in 1964). The figure includes 4 cases notified at death, 1 of which was diagnosed posthumously. These figures suggest that the comparative freedom from tuberculosis enjoyed by the community in recent years is, as has happened with other communicable diseases in the past, leading to a lack of awareness of its possible existence. The more tuberculosis fades from the community scene the less likely is it to be recognised and dealt with appropriately.

Tuberculosis Register:

The number of cases contained in the West Cumberland Tuberculosis Register at the 31st December, 1966 was 1350 respiratory forms and 67 non-respiratory, totalling 1417 (1437 in 1965). Of these, 36 were frankly infectious at some time during the year, of which 24 were found so at the time of diagnosis.

Deaths:

Three deaths occurred again this year (3 in 1965) in cases known to the Chest Clinic and one death was identified as due to tuberculosis at autopsy. These were all in the older age groups (65 + years) and associated with other disabling conditions.

Contacts of Cases of Tuberculosis:

All familiar contacts of new cases have been seen at either Clinic sessions in hospital outpatients; or referred to the Mass X-ray Unit, or where the contact resides outside Cumberland, advised attendance at their local Chest Clinic.

The Mass X-ray Service has attracted a somewhat larger known attendance of contacts than in recent past years, the number of contacts known to have attended in 1966 being 498 (283 in 1965). Of young contacts seen, 2 below the age of 5 years were notified as cases of active disease.

Prophylactic vaccination with B.C.G. was carried out on 423 contacts (426 in 1965) the majority of whom were below 13 years of age.

Case Finding Procedures:

These have not varied from long established practice of Mass X-ray activities on all new hospital outpatients, routine antenatal chest x-rays on full-sized films of all booked pregnancies, and the very occasional—and extremely un-rewarding—works and public surveys. The routine tubercullin testing of school children prior to B.C.G. vaccination under the School Medical Service programme brings a small—and annually decreasing—number of previously unknown reactor children to Chest Clinic supervision. No significant number of these have been found diseased or subsequently to develop disease.

Full details of Mass X-ray Unit activities are included in the Annual Report of the Director of the Unit, published elsewhere.

APPENDIX II

Annual Report on Tuberculosis and Other Chest Diseases in East Cumberland in 1966 by Dr. W. H. Morton

Introduction

The Chest Centre statistics for 1966 show little alteration in the trend as far as tuberculosis and pulmonary cancer are concerned. The number of new cases of active pulmonary tuberculosis was 35 in 1966 compared to 34 in 1965. The number of cases of tuberculosis under supervision at the Chest Centre has dropped from 1248 to 1013, although the number of cases on the active register increased slightly from 424 to 427. The diagnosis of the disease was confirmed bacteriologically in just under 50% of the new cases.

The number of new cases of bronchial carcinoma for 1966 unfortunately shows a slight increase compared to 1965 but the figure is still below that of 1964. Of the new cases only 7 were submitted for surgery. The Cytotoxic Drug therapy trial still continues and it is yet too early to draw any conclusions from this.

The number of new cases of bronchiectasis seen at the chest centre in 1966 is a new low record, and the majority of these cases were in adults. All cases are treated by intensive physiotherapy, including postural drainage, and no case has been referred for surgery during the year. The steady decline of serious respiratory disease in childhood along with prompt detection and treatment with antibiotics has obviously contributed most to this state of affairs. Indeed, bronchiectasis should largely disappear completely now as a surgical problem.

Chronic bronchitis with or without emphysema is the commonest condition seen in new patients, and, in spite of treatment, continues to take an abnormally high toll of life in this country; it is estimated that five times as many people die of this disease as are killed on the roads.

Tuberculosis

Table 1 shows the number of notifications throughout England and Wales for 1966 and the preceding five years:—

Table 1

Year				Pulmonary	Non-Pulmonary
1961	...	...	...	19,187	2,728
1962	...	...	...	17,973	2,685
1963	...	...	...	16,355	2,608
1964	...	...	...	15,026	2,581
1965	...	...	...	13,552	2,550
1966	...	...	...	12,461	2,253

Table 2 shows the number of notifications in the area for the past ten years.

Table 2

Year	East Cumberland			Pulmonary	Non-Pulmonary
1957	...	...	...	54	12
1958	...	...	...	47	15
1959	...	...	...	50	11
1960	...	...	...	19	6
1961	...	...	...	28	8
1962	...	...	...	23	2
1963	...	...	...	18	5
1964	...	...	...	25	6
1965	...	...	...	14	5
1966	...	...	...	11	4

There has been comparatively little change in the regimen of investigation and therapy in tuberculosis. No new drugs have been introduced, and therapy without present drugs has proved reasonably satisfactory in most cases. Comparatively few patients with tuberculosis require surgery. The number of cases of tuberculosis with organisms resistant to most drugs at the end of 1966 was 4.

The problem of tuberculosis in immigrants in this Country is still a serious one and little positive action has been taken by British Governments to prevent tuberculosis being imported. Most of the imported tuberculosis is found amongst Indians and Pakistanis. The majority of these immigrants settle and work in Midlands centres such as Birmingham and Bradford, and, as far as numbers go, this area has had comparatively few immigrants, suggesting that the problem in this area is insignificant. The actual number of immigrants suffering from tuberculosis in an area is not, however, the whole problem.

Much more serious is the problem of drug resistance in these cases. Primary drug resistance was shown by the M.R.C. report in 1963 to be much commoner in immigrants. Although during 1966 we have had only one case of tuberculosis in an immigrant in this area, this case is also drug resistant. In 1961 we had six immigrants in this area who were found to be suffering from tuberculosis. Unfortunately the immigrant discovered last year has been in Carlisle since 1961 and escaped our contact examinations.

Not only does this new immigrant have a positive sputum but the organisms present are resistant to first-line anti-tuberculous drugs. Moreover, in spite of his sojourn in Carlisle for six years, he cannot speak a word of English. He had obviously had treatment for tuberculosis previously in the Far East but because of language difficulties it is quite impossible to discover what drugs were then used in his treatment. Finally, during his stay in Carlisle he has been employed in a restaurant.

The risk to other people during this period has therefore been very real and dangerous. The possibilities of developing active disease with drug resistant tubercle bacilli creates immense problems as far as treatment is concerned. One must strongly emphasise therefore the need for complete medical and x-ray examination of all prospective immigrants before they are allowed into the Country. This measure demands urgent priority.

Contact examinations have continued as in previous years, and no contact has been found to be suffering from active disease. All susceptible contacts have been vaccinated with B.C.G. vaccine.

Table 3 shows the number of chest beds available during the year with the number of discharges for both 1966 and 1965.

Table 3

Hospital	Beds No. discharged No. discharged		
	Available	in 1966	in 1965
Ward, 18 Cumberland Infirmary	14	267	271
Longtown Hospital ...	26	146	141
Blencathra Hospital ...	11	27	43

Lung Cancer

Table 4 shows the number of cases of carcinoma of the lung seen at the chest centre during 1966 and the previous nine years.

Table 4

Year	East Cumberland			
1957	...	...	...	11
1958	...	...	...	27
1959	...	...	...	31
1960	...	...	...	20
1961	...	...	...	30
1962	...	...	...	29
1963	...	...	...	36
1964	...	...	...	38
1965	...	...	...	26
1966	...	...	...	29

The first report of the M.R.C. on the evaluation of therapy in bronchial carcinoma was published in November last. This concluded that the results of treatment in small celled carcinoma of the bronchus are very poor, and that neither surgery or Megavoltage radiotherapy appreciably influences the course of the disease; if anything, the advantage in this type of bronchial carcinoma lay with radiation therapy. In the squamous type of bronchial carcinoma on the other hand, providing the individual patient conforms to the accepted minimal standard required for surgery, then surgery here is obviously the therapy of choice.

APPENDIX III

MASS RADIOGRAPHY

REPORT ON THE WORK OF THE MASS RADIOGRAPHY UNIT DURING 1966

NOTE: Figures given in brackets throughout the report relate to the corresponding figures for 1965.)

18,556 (15,296) persons were examined by the Units during the year and of these 798 (687) were referred for clinical examination.

Table 1 shows the number of abnormalities revealed during 1966 throughout the whole of the Special Area.

TABLE 1

				No. of Cases found	Percentage of total examined	
ABNORMALITIES REVEALED						
(1) Non-tuberculous conditions:						
(a)	Bronchiectasis	...	30	(13)	.16	(.08)
(b)	Pneumoconiosis	...	13	(8)	.07	(.05)
(c)	Neoplasm		36	(17)	.19	(.11)
(d)	Cardiovascular conditions		42	(49)	.23	(.32)
(e)	Miscellaneous requiring investigation	...	13	(7)	.07	(.05)
(2) Pulmonary tuberculosis:						
(a)	Active		20	(22)	.11	(.14)
(b)	Inactive requiring supervision	...	67	(65)	.36	(.42)

Table 2 gives an analysis of the work of the mobile unit divided into the East and West Cumberland areas.

TABLE 2

EAST CUMBERLAND

WEST CUMBERLAND

[illegible]

Table 3 gives an analysis of the work of the Static Unit in Carlisle, the Static Unit at the West Cumberland Hospital and the work of the mobile unit while operating in a static role at Workington Infirmary.

283

Table 4 gives the relative figures as between East and West Cumberland for the past eight years.

TABLE 4

Year	EAST CUMBERLAND						WEST CUMBERLAND					
	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis	Active Tuberculosis	Inactive Tuberculosis	Neoplasm	Cardiac Conditions	Bronchiectasis	Pneumoconiosis
1959	33	40	13	241	37	3	14	24	4	39	15	71
1960	21	11	19	120	19	2	18	21	7	23	9	52
1961	20	11	24	144	23	4	13	20	5	24	10	42
1962	24	14	25	71	22	2	12	63	9	18	19	60
1963	17	4	21	67	27	6	8	58	3	23	18	37
1964	13	7	16	47	22	1	7	36	7	10	5	14
1965	10	15	9	40	12	—	12	50	8	9	1	8
1966	9	15	29	34	20	—	11	52	7	8	10	13

Table 5 refers solely to the area covered by the East Cumberland Hospital Management Committee and shows the number of new cases of neoplasm discovered.

TABLE 5

	1959	1960	1961	1962	1963	1964	1965	1966
No. of cases of neoplasm seen at Chest Centre	59	54	64	60	74	80	54	67
No. discovered by M.M.R.	13	19	24	25	21	16	9	29

Comments

The mass radiography figures for 1966 again stress the importance of the groups of people sent for examination by their own doctors and fully justify the modern concept of mass radiography examination. Whilst the examination of ordinary members of the public does result in the diagnosis of one or two cases of active tuberculosis and one or two cases of pulmonary carcinoma, in some of these cases at least the patient's own doctor has asked him to attend for x-ray although the patient himself does not give this information to our staff. The mass radiography unit is a service for the use of general medical practitioners and we feel that the service is not yet used to its fullest extent. Reading sessions continue to be carried out three times weekly and both technical and medical staff could cope quite easily with several hundred more patients referred by general practitioners.

The routine examination of hospital out-patients is also a very worth-while procedure as is evident by the figures relating to the static unit operating at the new West Cumberland Hospital.

APPENDIX IV

County Council Clinics

Centre		Address	Clinic Services
Alston	...	Cottage Hospital, Alston	Child Welfare, Dental.
Anthorn	...	Welfare Office, ... Anthorn.	Child Welfare, Vaccination and Immunisation.
Aspatria	...	St. Mungo's P. ... Aspatria	Ante-Natal, Child Welfare, Dental, Speech Therapy, Orthopaedic, Vaccination and Immunisation.
Brampton	...	Union Lane, ... Brampton	Ante-Natal, Child Welfare, Chir- opody, Dental, Orthopaedic, Vac- cination and Immunisation.
Broughton	...	Nurse's House, ... Little Broughton	Child Welfare
Carlisle	...	14, Portland Sq. . Carlisle	Child Guidance, Dental, E.N.T., Ophthalmic, Orthoptic, Orthopaedic, Speech Therapy, Vaccination and Immunisation, Cervical Cytology.
Cleator Moor	...	Ennerdale Rd., ... Cleator Moor	Ante-Natal, Child Welfare, Chiropody, Dental, Orthopaedic, Vaccination and Immunisation, Cervical Cytology.
Cockermouth	...	Harford House, ... Cockermouth	Ante-Natal, Child Welfare, Chiropody, Dental, Ophthalmic, Orthopaedic, Speech Therapy, Vac- cination & Immunisation, Cervical Cytology.
Crosby (Maryport)	...	Nurse's House, ... 6 Parkside, Crosby, Maryport	Child Welfare.
Dalston	...	Victory Hall, ... Dalston	Child Welfare, Vaccination and Immunisation.

Centre		Address		Clinic Services
Dearham	...	Nurse's House, ... Central Road, Dearham.		Child Welfare
Egremont	...	St. Bridget's ... Lane, Egremont		Ante-Natal, Child Welfare, Chiropody, Dental, Orthopaedic, Vaccination and Immunisation.
Frizington	...	Council ... Chambers, Frizington		Ante-Natal, Child Welfare, Dental, Vaccination and Immunisation.
Houghton	...	The Village ... Hall, Houghton		Child Welfare, Vaccination and Immunisation.
Hunsonby	...	The Village ... Institute, Hunsonby		Child Welfare, Vaccination and Immunisation.
Keswick	...	13-15 Bank St. ... Keswick		Relaxation, Child Welfare, Dental, Orthopaedic, Ophthalmic, Speech Therapy, Vaccination and Im- munisation.
Longtown	...	T.A. Centre, ... Longtown		Child Welfare, Dental, Orthopaedic Vaccination and Immunisation.
Lorton	...	1 Broomcroft ... Lorton		Child Welfare.
Maryport	...	24 Selby Terrace, Maryport		Ante-Natal, Child Welfare, Child Guidance, Orthopaedic, Speech Therapy, Vaccination and Im- munisation, Cervical Cytology.
Millom	...	18 St. George's ... Road, Millom		Ante-Natal, Child Welfare, Child Guidance, Dental, Speech Therapy, Surgical, Chest, Gynaecological, Medical, Minor Ailments, Ophthal- mic, Orthopaedic, Vaccination and Immunisation, Cervical Cytology, Family Planning.

Centre		Address	Clinic Services
Penrith	...	Brunswick Sq., ... Penrith	Ante-Natal, Child Welfare, Dental, Family Planning, Hearing Therapy, Vaccination and Immunisation, Psychiatric, Speech Therapy, Orthopaedic, Orthoptic, Cervical Cytology.
Scotby	...	The Village Hall, Scotby	Child Welfare, Vaccination and Immunisation.
Seascale	...	Gosforth Road, ... Seascale	Ante-Natal, Child Welfare, Dental, Chiropody, Orthopaedic, Vaccination and Immunisation.
Seaton	...	Miners' Welfare ... Hall, Seaton	Child Welfare, Vaccination and Immunisation.
Thornhill	...	Community ... Centre, Thornhill	Child Welfare.
Thursby	...	The Church Hall, Thursby	Child Welfare, Vaccination and Immunisation.
Wetheral	...	The Village Hall, Wetheral	Child Welfare, Vaccination and Immunisation.
Whitehaven Flatt Walks ...		Flatt Walks, ... Whitehaven	Ante-Natal, Child Welfare, Child Guidance, Chiropody, Dental, Family Planning, Hearing Therapy, Ophthalmic, Orthopaedic, School, Speech Therapy, Vaccination and Immunisation, Cervical Cytology, Orthoptic.
Mirehouse	...	Dent Road, ... Mirehouse, Whitehaven	Ante-Natal, Child Welfare, Dental, Vaccination and Immunisation.
Woodhouse	...	Woodhouse, ... Whitehaven	Ante-Natal, Child Welfare, Vaccination and Immunisation.
Wigton	...	Birdcage Walk, ... Wigton	Ante-Natal, Child Welfare, Chiropody, Dental, Orthopaedic, Speech Therapy, Vaccination and Immunisation, Cervical Cytology.

Centre		Address		Clinic Services
Workington	...	Park Lane, Workington	...	Ante-Natal, Child Welfare, Child Guidance, Chiropody, Dental, Family Planning, Hearing Therapy, Marriage Guidance, Orthopaedic, School, Speech Therapy, Cervical Cytology. (Note—Spastic Therapy Clinic held about three times a year.)
Salterbeck	...	Holden Road, Salterbeck, Workington	...	Ante-Natal, Child Welfare, Dental, Cervical Cytology, Vaccination and Immunisation.

NOTES